BYLAWS

OF THE

MEDICAL STAFF

OF

UH ST. JOHN MEDICAL CENTER

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OF
ST. JOHN MEDICAL CENTER

Approved
at the
Voting Staff
August 12, 2011

Approved
by the
Board of Directors
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RULES AND REGULATIONS OF THE MEDICAL STAFF

PREAMBLE

The Medical Staff of St. John Medical Center recognizes its responsibility for the quality of medical care provided by its members in cooperation with the hospital administration and subject to the ultimate authority of the Board of Directors. Therefore, the Medical Staff hereby organizes themselves in accordance with the Bylaws and Rules and Regulations hereto set forth.

DEFINITIONS

1. **ADMINISTRATION** means the Hospital President and other officers within the General Administration of the Hospital.

2. **ALLIED HEALTH PRACTITIONER (AHP)** means an individual other than a physician, dentist, podiatrist, or psychologist who is granted limited clinical privileges within the scope of licensure which can be exercised only under the supervision of or in collaboration with a physician member of the Medical Staff.

3. **BOARD OR BOARD OF DIRECTORS** means the Board of Directors of St. John Medical Center.

4. **CLINICAL PRIVILEGES or "Privileges"** means permission to provide medical or other patient care services in the Hospital, within well-defined limits, based on the practitioner's professional license, experience, competence, ability and judgment and includes all reasonable and appropriate access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

5. **CLINICAL ACTIVITY** means minimum utilization needed to assess competence or staff advancement as recommended by individual departments, set by the Medical Executive Committee and approved by the Board of Directors.

6. **COMPARABLE COMPETENCY** related to the board certification requirements of Article 3.2.10 is defined by the appropriate department chair in consultation with the Credentials Committee and is required in order for the Medical Executive Committee to recommend an exception to the board certification requirement. Guidelines for the department chair/Credential Committee's consideration are included in the Medical Staff policies and procedures related to initial appointment and reappointment.(3)

7. **COMPLETE APPLICATION** means an application for Medical Staff membership and any privileges which includes the application fee. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. An application that continues to be incomplete forty-five (45) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.

8. **DENTIST** means an individual with a D.M.D. or a D.D.S. degree who is licensed to practice dentistry in the State of Ohio.

9. **HOSPITAL** means Westlake Health Campus Association dba St. John Medical Center.

10. **HOSPITAL PRESIDENT** means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital.

11. **IN GOOD STANDING** means, at the time of the assessment of standing, his/her membership and/or privileges are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leaves of absence).

12. **INVESTIGATION** means a process specifically instigated by the Medical Executive

Committee to determine the validity, if any, to a concern or complaint raised against a Medical Staff member or individual holding clinical privileges relating to competence and conduct, and does not include activity of the Medical Staff Wellness Committee.

13. **LIMITED LICENSED PRACTITIONER** means a member of the Medical Staff with a limited license, i.e., podiatrist, dentist, oral surgeon, or psychologist.

14. **MEDICAL EXECUTIVE COMMITTEE (MEC)** means the elected group of Active members of the Medical Staff empowered to act for the Medical Staff.

15. **MEDICAL STAFF** means all physicians, dentists, podiatrists, and psychologists who have been granted membership pursuant to these Bylaws.

16. **MEDICINE AND MEDICAL SUBSPECIALTIES:** For the purpose of the election of at-large members, includes allergy/immunology, cardiology, dermatology, emergency medicine, endocrinology, family medicine, gastroenterology, hematology/oncology, internal medicine, infectious diseases, nephrology, neurology, pediatrics, psychiatry, pulmonary medicine, radiology and nuclear medicine, physical medicine/rehabilitation, and rheumatology.(8)

17. **ORAL SURGEON** means a dentist who has successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education.

18. **PHYSICIAN** means an individual with an M.D. or a D.O. degree who is licensed to practice medicine in the State of Ohio.

19. **PODIATRIST** means an individual with a D.P.M. degree who is licensed to practice podiatry in the State of Ohio.

20. **PRACTITIONER** means, unless otherwise expressly provided, any physician, dentist, podiatrist, or psychologist, or any Allied Health Practitioners who provides services to patients in the Hospital subject to these Bylaws.

21. **PROCTORING** means that form of focused evaluation typically carried out by a peer's concurrent observation and assessment, or where appropriate, by retrospective review of documentation and assessment of a practitioner's exercise of clinical privileges.

22. **PSYCHOLOGIST** means an individual with a doctoral degree in psychology, school psychology, or deemed equivalent by the Ohio State Board of Psychology, who has had at least two years of supervised professional experience in psychological work (one of which was after the doctoral degree was obtained), and who has been licensed to practice psychology in the State of Ohio.

23. **SURGERY AND SURGICAL SUBSPECIALTIES:** For the purpose of the election of at-large members, includes anesthesiology, colorectal surgery, general surgery, neurosurgery, obstetrics/gynecology, ophthalmology, oral surgery, orthopaedic surgery, otolaryngology, pain management, pathology, plastic surgery, podiatry, urology and vascular surgery.(8)

ARTICLE I
NAME

The name of this Medical Staff shall be the Medical Staff of St. John Medical Center.

ARTICLE II
PURPOSE

The purpose of this Medical Staff shall be:

2.1 To provide a structural framework under which patients admitted to the Hospital and/or to any of its facilities, departments, or services, may receive appropriate medical and dental care, free of discrimination based upon sex, religion, race, color, creed or national origin.

2.2 To provide a Medical Staff structure in which its members can engage in the practice of medicine in an atmosphere of equality of opportunity, absent of discrimination, with the guarantee that no physician shall be discriminated against by the Hospital and/or the Board of Directors and/or the Hospital President with respect to: (a) Medical Staff membership and clinical privileges; (b) Medical Staff committee representation; (c) availability of hospital beds; (d) the right to choose professional consultants; (e) impartial and fair treatment and access to grievance procedures; or (f) otherwise, because of status as a doctor of medicine, osteopathy, dentistry, podiatry, or psychology, or because of sex, religion, race, color, creed or national origin.

2.3 To emphasize that the Medical Staff, in collaboration with the Administration, oversees responsibility for the provision of medical care to patients and that the Board of Directors and Hospital President consider the recommendation of the Medical Staff in matters affecting the Medical Staff which require approval by the Board of Directors.

2.4 To provide a means whereby issues concerning the Medical Staff and the Hospital may be brought to the attention of the Board of Directors and/or the Hospital President.

2.5 To foster maintenance of quality educational standards in the teaching of all medical personnel which will lead to continuous advancement, professional knowledge, and skill.

2.6 To strive for continuous improvement in the quality of patient care in the Hospital and thus promote confidence in the Hospital as a community enterprise.

ARTICLE III
MEMBERSHIP

3.1 Nature of Medical Staff Membership

Membership on the Medical Staff and/or the opportunity to exercise clinical privileges is extended to certain practitioners for specified intervals of time but is not a right of any practitioner. Every practitioner who seeks or enjoys staff membership must continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

3.2 Qualifications for Membership

In order to demonstrate to the Medical Staff that patients treated by the applying practitioner can reasonably expect to receive quality care, basic qualifications for Medical Staff membership shall include documentation or demonstration of:

3.2.1 Current licensure in the State of Ohio and DEA licensure if utilizing prescriptive authority(3);

3.2.2 Relevant education, training and experience;

3.2.3 Current professional competence;

3.2.4 Physical and mental health status appropriate for the privileges requested;

3.2.5 Willingness to participate in the discharge of Medical Staff responsibilities to the extent required by these Bylaws;

3.2.6 An ability to work cooperatively and collaboratively with members of the Medical Staff, Board of Directors, Hospital management and employees, and patients and families;

3.2.7 Adequate verbal and written communication skills;

3.2.8 Professional liability insurance which meets the minimum requirements established by the Board of Directors;

3.2.9 Have offices and residences, which in the reasonable opinion of the MEC, are located in such proximity of the Hospital to provide for the provision of the continuity of care; and

3.2.10 In the case of memberships granted after July 1, 2005, Board certification or admissibility for certification in the practitioner's field of expertise, including subspecialty certification or admissibility if the applicant is requesting privileges in a subspecialty is required within five years of completion of training. Certification must be obtained through a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the Royal College of Physicians and Surgeons of Canada. Podiatrists, Dentists and clinical Psychologists must meet Board Certification requirements as specified by their respective departments. Failure to maintain or achieve certification is grounds for termination from the staff. The Medical Executive Committee may recommend, and the Board of Directors may approve, exceptions based upon community need and documented comparable competence. [Refer to Medical Staff Policies and

Procedures MSS.1-01 (Credentialing Process for Initial Application – Medical Staff) and MSS.2.0 (Credentialing – Medical Staff and Allied Health Membership Renewal)][3]

(a) Physicians appointed prior to July 1, 2005, who were board certified at the time of appointment, but fail to maintain that certification will be grandfathered.[3]

(b) Physicians appointed after July 1, 2005, who were board certified at the time of appointment, but fail to maintain that certification will be notified they have until their next renewal date to become recertified or they may be considered ineligible to apply for membership renewal.[3]

(c) Physicians appointed after July 1, 2005, who were not board certified at the time of appointment and fail to obtain certification within five years of completion of training, will be notified they have until their next renewal date to obtain certification or they may be considered ineligible for membership renewal.[3]

3.3 Effects of Other Affiliations

No practitioner shall automatically be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely by virtue of licensure to practice in this or any other state, or certification by any clinical board, or because of prior or current staff membership at another health care facility or in another practice setting; nor shall any practitioner automatically be entitled to membership renewal or particular privileges because the practitioner had, or presently has, staff membership or those particular privileges at this Hospital or holds a contract at or is employed by this Hospital.

3.4 Non-Discrimination

No aspect of Medical Staff appointment shall be denied because of status as a doctor of medicine, osteopathy, dentistry, podiatry, or psychology, or because of sex, religion, race, age, creed, color, national origin or handicap.

3.5 Responsibilities and Ethical Conduct

Acceptance of Medical Staff membership, and/or clinical privileges, shall constitute the Medical Staff member's agreement to:

3.5.1 abide by the Principles of Medical Ethics adopted by the American Medical Association or the American Osteopathic Association; or the Code of Ethics of the American Dental Association, the American Podiatric Association, or the American Psychological Association, whichever is applicable.

3.5.2 abide by the Code of Ethical and Religious Directives for Catholic Health Care Facilities, as approved by the Diocese of Cleveland.

3.5.3 provide patients with the quality of care meeting professional standards of the Medical Staff of this Hospital.

3.5.4 abide by the Medical Staff Bylaws, Rules and Regulations and Departmental and Divisional Rules and Regulations, and all relevant standards and policies of the Hospital.

3.5.5 accept and appropriately discharge such Medical Staff committee, department, Hospital, and other assignments for which the member is responsible by appointment, election or otherwise.

3.5.6 prepare and complete medical records in a timely fashion for all patients under the member's care in the Hospital, but in all cases within the time required by applicable accreditation standards and applicable medical records policies.

3.5.7 make arrangements for appropriate and timely medical coverage for the member's patients.

3.5.8 notify the Medical Staff Services Department or the Medical Staff President of

3.5.8.1 any change in licensing, DEA registration/schedules, or professional liability insurance coverage;
3.5.8.2 restriction, denial, surrender of, or material change in clinical privileges or membership elsewhere;
3.5.8.3 any adverse professional liability judgment, criminal judgment, drug or alcohol conviction;
3.5.8.4 imposition of any limitation, sanction, restriction, or exclusion from participation in the Medicare, Medicaid, or other applicable federal or state health care programs;
3.5.8.5 the filing of charges by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or by any state or governmental authority; or
3.5.8.6 removal from the provider panel of any managed care organization or third party payor for reasons related to allegations of fraudulent behavior, overbilling or poor clinical quality.

Notification of any change must be made by 5:00 p.m. of the next business(6) day.

3.5.9 Notify the Chairperson of the Medical Staff Performance Improvement Committee, the Quality and Resource Management Department or the Medical Staff Services Department of any notification of review or inquiry from the State Peer Review Organization with regard to patients in this Hospital.

3.5.10 Refuse payment from or to pay to another practitioner, either directly or indirectly, openly or by secret arrangement, any part of a fee received for professional services.

3.6 Medico-Administrative Positions

Physicians with Hospital contracts whose duties include both administrative and clinical responsibilities must be members of the Medical Staff and must obtain clinical privileges in the same manner as any other Medical Staff member. When a contract exists, and unless otherwise expressly provided, the contract shall clearly define the relationship between termination of the contract by the Hospital and reduction or termination of clinical privileges through provisions of these Bylaws. In the event of a conflict, express or implied, between the terms of such contract express or implied, between the terms of such contract regarding the contractor's privileges and the Bylaws, the terms of the contract shall prevail and shall control the relationship between the practitioner and the Hospital. The Hospital President may consult the President of the Medical Staff regarding such positions; provided that final decisions relating to such positions reside with the Hospital President.

3.7 Dues

Payment of dues is a requirement of Medical Staff membership. The MEC shall set the amount of annual dues. Members of the following staff categories are exempt from payment of dues: Senior Staff, House Physicians and Emeritus Staff. Failure to pay such dues in a timely manner will jeopardize members' privileges.

3.8 Review of Members

3.8.1 Focused Peer Review of Initial Members

All initial grants of privileges shall be subject to evaluation, such as proctoring, under these Bylaws and otherwise reviewed for compliance with the relevant departmental peer review criteria.

3.8.2 Ongoing Peer Review of Members

All members and privilege holders not otherwise subject to initial review are reviewed for compliance with the relevant department peer review criteria on an on-going basis. In addition to information gathered under routine screening determined by the department, such as periodic chart review, proctoring on a rotational basis, monitoring of diagnostic and treatment techniques, and discussions with other professionals, complaints and concerns are analyzed in light of the department peer review criteria. Peer review analysis shall be conducted by the department practice committee for reporting quarterly to the department meeting for action. Members are kept apprised of reviews of their performance. Performance monitoring, corrective action or other measures are implemented or recommended.

3.8.3 Peer Review

To fulfill its responsibility for the quality and safety of patient care, the Medical Staff conducts peer review exclusively according to its standards and processes as set forth in these Bylaws.

3.8.3.1 Peer Reviewers

(a) Duty of Members

Members have a duty to serve as peer reviewers, to cooperate in any and all phases of peer review of the services they provide to patients in the Hospital, and to otherwise participate in peer review. A member's unreasonable refusal to serve on peer review committees or otherwise provide reasonably requested peer review services, or to cooperate with peer review of the member's practices or conduct can result in corrective action under these Medical Staff Bylaws. No Medical Staff member is excluded from serving as a peer reviewer because he/she is or is not a hospital employee, has or does not have a contract with the hospital or practices a particular specialty.

(b) Conflicts of Interests

If a member of a committee is not a disinterested or impartial party for

the purpose of the peer review, he/she shall disqualify him/herself and the Medical Staff President, in consultation with the Chief Medical Officer or the Hospital President, shall appoint a replacement. Individuals involved in peer review activities shall not have an economic interest in and/or a conflict of interest with the subject of the peer review activity. Impartial peer would exclude individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance of the potential of bias for or against the subject of the peer review. The fact that an individual is employed by a physician practice group shall not, in and of itself, constitute a conflict of interest.

(c) Indemnification and Immunity

Hospital shall indemnify, defend (or pay the cost of defending) and hold each representative of the Medical Staff and Hospital harmless from liability to an applicant or member for damages or other relief for any good faith action taken or statements or recommendations made within the scope of his/her duties as a representative of the Medical Staff or Hospital. Each representative of the Medical Staff and Hospital and all third parties shall be exempt as mandated by Ohio Revised Code Sections 2305.24 et seq. and 42 U.S.C. 11111, from liability to an applicant or a Member for damages for providing information to a representative of the Medical Staff or Hospital concerning such individual who is, or has been, an applicant to the Staff or Member or who did, or does, exercise clinical privileges or provide services at this Hospital.

3.8.3.2 Practice Committees

The Practice Committees of the Medical Staff Departments and other Medical Staff committees, such as the Medical Executive Committee and Credentials Committee, conduct peer review and serve as medical peer review committees. It is expected that Medical Staff Departments which do not have a formal practice committee as listed in Article IX shall conduct their peer review as part of their department meetings. Those portions of the department meetings dedicated to peer review are protected by all Federal and State of Ohio peer provisions.(7) All such committees and their members comply with the requirements of these Bylaws, including Bylaws provisions regarding conflict of interest, processes, training and confidentiality, as well as relevant Hospital policies. Divisions/departments such as those with a limited number of members, those consisting of a single group practice, contracted services, or system service lines may delegate peer review responsibilities with the Medical Executive Committee's consent. The Medical Executive Committee may request the delegated entity to create policies related to the divisions/departments' peer review process for the Medical Executive Committee's approval.(4) Refer to the Medical Staff policies and procedures related to peer review.(6)

3.8.3.3 External Peer Review

External peer review may be used to inform Medical Staff peer review as delineated under these Bylaws.

The Credentials Committee or the Medical Executive Committee, upon request from a Department or upon its own motion, in evaluating or investigating an applicant, privileges holder, or member, may obtain external peer review in the following circumstances:

(a) Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action;

(b) No current Medical Staff member can provide the necessary expertise in the clinical procedure or area under review;

(c) To promote impartial peer review;

(d) In departments limited by an exclusive contract to a single employer or group;

(e) Where, in the opinion of the Medical Staff President, in consultation with the Chief Medical Officer or the Hospital President, it is in the best interest of the Hospital to conduct external review.

3.8.3.4 Purpose and Standards of Peer Review

(a) Purpose

Patient safety and quality of care must be the goal. Peer review is not used as punishment or retribution.

(b) Medical Staff Standards

Each department and section establishes and updates standards of care to be met by each professional holding privileges, based on generally accepted clinical guidelines and practices, including criteria for measuring members' compliance with the standards set and triggers for corrective action. Standards and any updates to the standards are reviewed and adopted by the Medical Executive Committee. Standards are available at all times to all members.

3.8.3.5 Protective Action

At any point in the process of peer review, a member or privileges holder may be referred to the Wellness Committee or may, in those extreme conditions defined in these Bylaws, be subject to summary suspension to protect patients and promote safety.

3.8.3.6 Triggering Peer Review

(a) Initial Privileges

All privileges initially granted to new members, held as temporary privileges, or granted as additional privileges to an existing member, are subject to focused peer review (FPPE[1]) to validate the grant of privileges. FPPE may include, but not be limited, to the following:[1]

i) Proctoring

Proctors are assigned from the Department Practice Committee by its chair. The proctor reports to the Committee in writing and includes patient safety, professional competence or conduct issues. At the end of the evaluation period, or sooner if deviations from standards or other concerns warrant, the Department Chairperson assesses proctoring reports as part of the Practice Committee evaluation.

ii) Other Types of Review

In addition to proctoring or, in circumstances in which proctoring is not suitable, instead of proctoring, the Practice Committee uses chart review, practice pattern evaluation, external review, or other appropriate tools to evaluate initial privileges.

(b) Ongoing Peer Review (OPPE[1])

i) Members' Professional Practices

The practices of members and others holding privileges are consistently evaluated according to the standards developed by the Department and adopted by the Medical Executive Committee.

ii) Concern/Event/Issue/Incident Evaluation

Concerns raised by regular section or department peer review committee activity are evaluated in light of pre-event occurrences and systemic factors. Complaints or other concerns raised outside of peer review, including self-reported incidents, are referred to the appropriate section or department peer review committee. The subject of review is included early in the review process and as appropriate throughout, to promote the sharing of information.

The imposition or continuation of a summary suspension or restriction is a precaution only and does not constitute a finding of fault on the part of the individual and shall not give rise to a report to the National Practitioner Data Bank unless it exceeds 30 days[1] provided that this shall not prohibit the reporting of a final adverse action following the policies and procedures set forth below.

3.8.3.7 Outcomes of Peer Review

a) Department Chairperson Review

At the end of the evaluation period, or sooner if deviations from standards or other concerns warrant, the Department Chairperson

assesses review reports as part of the Practice Committee evaluation.

b) Recommendations for System Improvement

The Practice Committee reports to the Department and can recommend, for referral, changes in systems operating in the Department, Medical Staff or Hospital to improve patient safety and care.

c) Recommendations for Members

The Practice Committee report can instead, or also, make recommendations regarding the member, if warranted by the information gathered. All recommendations for improvement are supported by Committee findings and are reported to the member and the Department Chairperson, specifying the standards at issue, deviations identified and steps that should have been taken and are recommended for future compliance and remediation.

The Practice Committee review is considered by the Department and acted upon as part of its peer review responsibilities. If appropriate under Department standards, performance monitoring, corrective action or other measures are implemented or recommended. The Department can request the Medical Executive Committee to initiate investigation or, if the information gathered to date warrants, request the Medical Executive Committee to summarily suspend the member, recommend restriction of privileges or take other appropriate corrective action.

d) Data Bank Reporting

No peer review activity, actions or recommendations as described in this Article are reportable to the National Practitioner Data Bank except where required by applicable law.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 Categories

The categories of the Medical Staff shall include Courtesy, Associate, Active, Senior, Consulting, Retired, Emeritus and House Physicians.(7) Allied Health Professionals and Physicians-in-Training are described in this Article, but they are not members of the Medical Staff. At membership renewal, the member's staff category shall be determined.

4.2(7) Courtesy Staff

4.2.1 Qualifications(7)

The Courtesy Staff shall consist of members who:

(a) meet general qualifications for Medical Staff membership as stated in Section 3.2; and

(b) do not maintain the requirements to qualify for Active or Associate Staff Status (see Rules and Regulations of the Medical Staff).

4.2.2 Prerogatives

Courtesy Staff members shall be entitled to:

(a) exercise such clinical privileges as have been granted pursuant to Article VI;

(b) attend regular meetings of the Medical Staff, Department and Division without vote. Courtesy staff may be advanced to Active staff after meeting clinical activity requirements (as defined by their respective department) as well as meeting attendance requirements as outlined in Article X, Section 10.6.1; and

(c) attend assigned committee meetings with vote, but may not chair a committee.

Courtesy Staff members shall not be eligible for election to Medical Staff office nor Department Chairpersonship, and may not be appointed Division Chief.

4.2.3 Responsibilities

Courtesy Staff members shall:

(a) discharge the basic responsibilities as stated in Section 3.5;

(b) utilize the Hospital to a sufficient degree to allow for adequate assessment of ability to provide quality care to patients;

(c) participate in the quality management program, utilization review, and other activities of the Medical Staff;

(d) attend assigned committee meetings; and

(e) pay staff dues.

4.3[7] Associate Staff

4.3.1 Qualifications

The Associate Staff shall consist of members who:

(a) meet general qualifications for Medical Staff membership as stated in Section 3.2; and

(b) have serve a minimum of one (1) year on the Courtesy Staff[7] and have been recommended for advancement based on clinical activity requirements.

4.3.2 Prerogatives

Associate Staff members shall be entitled to:

(a) exercise such clinical privileges as have been granted pursuant to Article VI;

(b) attend regular meetings of the Medical Staff without vote and Department and Division meetings with vote; and

(c) attend assigned committee meetings and may chair committees if so appointed.

Associate Staff members shall not be eligible for election to a Medical Staff office or Department Chairpersonship, but may be appointed as Division Chief.

4.3.3 Responsibilities

Associate Staff members shall:

(a) discharge basic responsibilities as stated in Section 3.5;

(b) regularly admit and/or care for patients in the Hospital or regularly be involved in other medical functions in the Hospital;

(c) participate in quality management, utilization review, and other activities required of the Medical Staff;

(d) meet meeting attendance requirements as stated in Section 10.6.1 if anticipating advancement to the Active Staff; and

(e) pay staff dues.

4.3.4 Term of Associate Status

A member shall serve no less than one (1) year on the Associate Staff during which time the activity level of the member shall be documented. Based on the activity level, (see Rules and Regulations of the Medical Staff) the member may remain on Associate Staff or be transferred to the appropriate staff category at membership

renewal.

4.4[7] Active Staff

4.4.1 Qualifications

The Active Staff shall consist of members who:

(a) meet general qualifications for Medical Staff membership as stated in Section 3.2;

(b) meet one of the following specific qualifications:

(i) regularly admit and/or care for patients in the Hospital and are regularly involved in other medical functions in the Hospital such that the required activity level is maintained during each membership period (with minimum utilization to be set by the MEC after review of recommendations by the individual departments); or

(ii) currently serve as a Medical Staff Committee Chairperson for a term of not less than two (2) years; or

(iii) current Active Staff members (as of March 27, 2020) requesting membership with no clinical privileges who continue to meet attendance requirements for Active Staff members per Article 10.6.1.[7]

(c) abide by meeting attendance as set forth in Article X, Section 10.6; and

(d) have satisfactorily completed required memberships on the Courtesy or Associate[7] Staffs for a combined total of no fewer than two (2) years.

4.4.2 Prerogatives

Active Staff members shall be entitled to:

(a) exercise such clinical privileges as have been granted pursuant to Article VI;

(b) attend all regular and special meetings of the Medical Staff, Department, and Division with vote;

(c) be eligible to chair any committee as appointed; be eligible to be elected to the Medical Executive Committee;

(d) be eligible to be elected to Medical Staff office or Department Chairpersonship; and

(e) be eligible to be appointed Division Chief.

4.4.3 Responsibilities

Active Staff members shall:

(a) discharge basic responsibilities as stated in Section 3.5;

(b) perform the duties of any office or position to which elected or appointed;

(c) participate in quality management, utilization review, and other activities required of the Medical Staff;

(d) satisfy requirements for meeting attendance as set forth in Article X, Section 10.6.1;

(e) participate, if reasonably requested, in teaching and continuing medical education programs;

(f) reasonably provide, if requested, on-call coverage for Emergency Services;

(g) pay staff dues; and

(h) fulfill other Medical Staff functions as may be required of members.

4.5[7] Senior Staff

4.5.1 Qualifications

The Senior Staff shall consist of members who:

(a) meet general qualifications for membership as stated in Section 3.2;

(b) are Medical Staff members who have attained the minimum age of sixty (60) years and served St. John Medical Center in an aggregate of ten (10) years as Active Staff members; and

(c) request Senior Staff membership.

4.5.2 Prerogatives

Senior Staff members shall be entitled to:

(a) exercise such clinical privileges as have been granted pursuant to Article VI;

(b) attend all regular and special meetings of the Medical Staff, Department, and Division with vote;

(c) attend committee meetings as assigned with vote; chair any committee as appointed; and

(d) be eligible for election to Medical Staff office or Department Chairpersonship.

4.5.3 Responsibilities

Senior Staff members shall:

(a) discharge the basic responsibilities as stated in Section 3.5;

(b) not be required to have assigned duties or responsibilities not included in (a).

4.6[7] Consulting Staff

This category is for certain specialists or subspecialists who infrequently see patients in this Hospital (e.g., dentists, dermatologists, or psychologists, etc.); a specialist providing coverage of another specialist; or a sub-specialist with unique skills to fulfill a hospital need or provide external peer review.

4.6.1 Qualifications

The Consulting Staff shall consist of members who:

(a) meet general qualifications for membership as stated in Section 3.2;

(b) are not otherwise members of the Medical Staff;

(c) are members in good standing of the Medical Staff of another licensed/accredited hospital; and

(d) are willing and able to respond promptly when called to render clinical services.

4.6.2 Prerogatives

Consulting Staff members shall be entitled to:

(a) exercise such clinical privileges as have been granted pursuant to Article VI;

(b) attend meetings of the Medical Staff, Department and Division without vote;

(c) not be eligible to be elected to Medical Staff office nor Department Chairpersonship; nor be eligible to be appointed Division Chief; and

(d) distance and dues requirements shall not pertain to Consulting Staff members if the practitioner does not request admitting privileges.

4.6.3 Responsibilities

Consulting Staff members shall discharge the basic responsibilities as stated in Section 3.5.

4.7[7] Retired Staff

A retiring Medical Staff member will be automatically changed to the Retired Staff from his/her current staff status upon his/her notification to the Credentials Committee via the Medical Staff Services Department of his/her pending retirement. The Credentials Committee will initiate the change in status if he/she has been a member in good standing and met all requirements (paid outstanding dues and completed all medical records) as specified in the Bylaws. At the discretion of the Medical Executive Committee, any retired physician may engage in some form of medical practice (i.e.,whether providing house coverage at another facility, volunteering at a clinic, or teaching in some capacity, etc.)[4]

4.7.1. Qualifications

The Retired Staff shall consist of members who:

(a) have retired from practice, having no admitting or clinical privileges at St. John Medical Center[4]; and

(c) are members in good standing, having maintained requirements as specified in these Bylaws.

4.7.2 Prerogatives

Retired Staff members shall be entitled to:

(a) attend meetings of the Medical Staff without vote;

(b) attend, serve and vote on Medical Staff committees; and

(c) may attend social functions of the Medical Staff.[4]

Retired Staff are not eligible to be elected to Medical Staff office or Department Chairperson; and are not eligible to be appointed as Division Chief.

4.8[7] Emeritus Staff

A retiring or resigning Medical Staff member may be considered for the Emeritus Staff status upon meeting the following qualifications. At the discretion of the Medical Executive Committee, any retired physician may engage in some form of medical practice (i.e., whether providing house coverage at another facility, volunteering at a clinic, or teaching is some capacity, etc.)[4]

4.8.1 Qualifications

The Emeritus Staff shall consist of members who:

(a) have been members of the Active Staff an aggregate of ten (10) years sometime during his/her Medical Staff membership and have served the Medical Staff in an exemplary fashion or in a leadership role[4];

(b) have retired from practice; having no admitting or clinical privileges at St. John Medical Center or resigned from the Medical Staff in preparation of relocating to another area to practice[4];

(c) if retiring, have been recommended for or, if resigning, have requested Emeritus Staff membership[4]; and

(d) Members must have been in good standing, having maintained requirements as specified in these Bylaws.

4.8.2 Prerogatives

Emeritus Staff members shall be entitled to:

(a) attend meetings of the Medical Staff without vote;

(b) may attend, serve and vote on Medical Staff committees and serve as chair of any such committee; and

(c) attend social functions of the Medical Staff.

Emeritus Staff are not eligible to be elected to Medical Staff office nor Department Chairperson; and are not eligible to be appointed as Division Chief;

4.9[7] House Physicians

House Physicians are those physicians contracted by the Hospital to examine and treat patients in lieu of such patients' respective attending physicians. The Medical Executive Committee may recommend exceptions based upon Hospital need and documented comparable competence.

4.9.1 Qualifications

House Physicians shall meet basic qualifications stated in Section 3.2 of these Bylaws.

4.9.2 Prerogatives

House Physicians shall be entitled to:

(a) exercise such clinical privileges as have been granted pursuant to Article VI;

(b) attend regular meetings of the Medical Staff and Department without vote;

(c) be assigned to committees.

House Physicians shall not be eligible to vote, hold elective office, nor chair a committee.

4.9.3 Responsibilities

(a) discharge the basic responsibilities stated in Section 3.5;

(b) uphold contractual obligations.

4.10[7] Allied Health Professionals (AHP)

Allied Health Professionals whose services require credentialing by the Medical Staff shall be bound by this Section 4.11, hospital policies and procedures and Ohio law relating to the scope of their respective practices. Each AHP shall have at least one qualified supervising or collaborating physician who is a member of the Medical Staff to the extent required by law. AHP shall not have admitting privileges, and the extent of their activities shall be determined by the Rules and Regulations of the Department/Division to which they are assigned. Clinical privileges shall be delineated on an individual basis, shall be limited to the scope of licensure, and must be approved by the MEC and the Board of Directors. Examples of practitioners in this category include physician assistants, advance practice nurses, CRNAs, Anesthesiologist Assistants, optometrist, licensed counselor, nurse midwives, etc.[5]

4.11[7] Physicians-in-Training

Physicians-in-Training have graduated from an accredited medical school and are participating in post-graduate training at the Hospital. They shall be governed by the curriculum, Rules and Regulations of the program.

4.12[7] Change of Status Outside of Membership Renewal Cycle

A Medical Staff member may request a change in status outside of the membership renewal cycle as follows:

4.12.1[7] A Courtesy Staff member may request Associate membership after one (1) year if the requirements of the status requested are fulfilled. A Courtesy Staff member may request Active Staff membership after two (2) years if the requirements of the status are fulfilled.[7]

4.12.3 An Associate Staff member may request Active Staff membership after one (1) year if the status requirements are fulfilled.

4.12.4 If a practitioner's staff status has been reduced, he/she may request a change in status after one (1) year if the requirements are met.

ARTICLE V
APPOINTMENT/RENEWAL

5.1 General Medical Staff Membership and Clinical Privileges

Applications for membership on Medical Staff, requests for modification of staff membership, and requests for initial clinical privileges or for renewal of clinical privileges shall be considered and evaluated by the Medical Staff through its designated committees, departments and divisions, and its recommendations transmitted to the Board of Directors for action. All applicants are evaluated for membership and privileges consistently, using those Medical Staff peer review criteria adopted consistent with these Bylaws, and applied through the processes established in these Bylaws.

5.2 Burden of Producing Information

In connection with all applications for membership or advancement, the applicant shall have the burden of producing sufficient information for an adequate evaluation of his/her qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for the denial of the application.

5.3 Duration of Membership

Initial membership shall be to the Courtesy Staff for a period not less than twelve (12) months.(7)

Membership shall be renewed for a period of up to two (2) years.

5.4 Initial Application

Upon receipt of payment of the non-refundable application fee and first year's staff dues, the processing of the application will begin.

Each applicant shall provide all information required on the hospital application for appointment to the Medical Staff form. This form shall minimally request:

5.4.1 the applicant's qualifications, including but not limited to, documentation of current Ohio licensure, professional training and experience, Board Certification status, current DEA certificate, and current professional competence;

5.4.2 physical and mental health status;

5.4.3 three (3) peer references able to provide written information regarding the practitioner's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism;

5.4.4 documentation of current malpractice liability coverage for the clinical privileges sought to be exercised in the amount required by the Board of Directors;

5.4.5 previously successful or currently pending professional disciplinary actions or the voluntary relinquishment of any professional licensure, registration (including DEA), or society membership;

5.4.6 voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

5.4.7 final judgments or settlements against the applicant in professional liability actions in the past five (5) years; and

5.4.8 departmental assignment and clinical privileges desired.

5.5 Applicant's Agreement

All applicants for Medical Staff membership as part of the application process shall acknowledge in writing that they:

5.5.1 received, read, and agree to be bound by these Bylaws, Rules and Regulations;

5.5.2 agree to abide by all applicable federal and state laws, relevant Hospital policies and Departmental and Divisional Rules and Regulations;

5.5.3 are willing to appear for interviews as part of the application process;

5.5.4 authorize Hospital representatives to consult with others who have information bearing on applicants' competence, character, qualifications and performance;

5.5.5 consent to inspection of records and documents which may be material to an evaluation of applicants' qualifications and competence to carry out the clinical privileges requested, including the National Practitioner Data Bank;

5.5.6 release from liability all representatives of the Hospital, Board of Directors, and Medical Staff for their acts performed in good faith and without malice in connection with evaluation of the applicants;

5.5.7 release from liability all individuals and organizations providing information regarding the applicant, including otherwise confidential information;

5.5.8 pledge to provide for continuous quality care for their patients;

5.5.9 acknowledge responsibility for timely payment of Medical Staff dues; and

5.5.10 agree to accept and fulfill committee assignments and on-call duties for Emergency Services as determined by the Medical Staff, if reasonably requested.

5.6 Complete Application

An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information has been verified from primary sources, with receipt of the application fee. An application shall become incomplete if the need arises for new, additional or clarifying information at any time. An application that continues to be incomplete forty-five (45) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.

5.7 Route of Completed Application

5.7.1 An application will be confirmed as complete by the Medical Staff Services Department, and the applicant will be so notified.

5.7.2 Once the application is deemed a complete application, the relevant Department Chairperson shall be notified by Medical Staff Services to review the application and to provide his/her written recommendation on the application form within thirty (30) working days of such notification. The Department Chairperson may, at his/her discretion, interview the applicant. The Department Chairperson, after consultation with the appropriate Division Chief and members of the Department, will make a recommendation to the Credentials Committee.

5.7.3 The application will be forwarded to the Credentials Committee for review. The Credentials Committee may elect to interview the applicant and seek additional information. The Credentials Committee will act upon the application as soon as is practical, but no later than sixty (60) working days from the application being confirmed as complete with or without departmental input. The recommendation of the Credentials Committee will be written on the application form by the Credentials Chairperson, and the application forwarded to the MEC.

5.7.4 The MEC shall consider the application at its next regular meeting. The MEC may request additional information, return the application to the Credentials Committee for further investigation, and/or elect to interview the applicant prior to formulating its recommendation.

(a) Deferral:

Action by the MEC to defer the application for further consideration must be followed up within sixty (60) days with a favorable or an adverse recommendation to the Board of Directors, or a designated committee of the Board of Directors.

(b) Favorable recommendation:

The MEC shall promptly forward the application, together with supporting documents to the Board of Directors, or a designated committee of the Board of Directors.

(c) Adverse recommendation:

The Medical Staff President, on behalf of the MEC, shall promptly inform the applicant by a written notice sent by certified mail, return receipt requested, which includes the basis for the adverse recommendation. This notice shall conform to the requirements set forth in Article XII, and the applicant shall be entitled to a hearing pursuant to Article XII.

5.8 Board of Directors Action

5.8.1 If the Board concurs with the favorable recommendation of the MEC, the decision shall be deemed final action on the application, and the applicant shall be notified in writing.

5.8.2 If the decision of the Board of Directors is contrary to the recommendation of the MEC, the Board may submit the matter to a joint committee of the Board of Directors and the Medical Staff for review and recommendation before making a final decision.

5.8.3 If the Board concurs with an adverse recommendation of the MEC, the Hospital

President shall promptly inform the applicant by a written notice, sent by certified mail, return receipt requested, which includes the basis for the adverse decision. This notice shall conform to the requirements set forth in Article XII, and the applicant shall be entitled to an appellate review as delineated in Article XIII.

5.8.4 Notice of the final appellate review decision of the Board of Directors shall be given, through the Hospital President, to the Medical Staff President, and to the applicant by means of written notice via certified mail, return receipt requested.

5.8.5 A decision and notice to appoint shall include, if applicable:

(a) the staff category to which the applicant is appointed;

(b) the department to which the applicant is assigned;

(c) the clinical privileges granted; and

(d) any special conditions attached to the appointment.

5.8.6 The Board of Directors may delegate all or a portion of its authority under this Section 5.8 to one or more committees of the Board of Directors.

5.9 Document Safeguard

All applications and related material are the property of the Hospital and shall be kept in the custody of the Hospital Administration.

5.10 Time Period for Processing Applications

Applications for Medical Staff appointment shall be considered in good faith in a timely manner by all persons and groups required by these Bylaws.

While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a suggested, but not binding, guideline for routine processing of applications.

5.10.1 Information collection and verification by the Medical Staff Services Department: sixty (60) days

5.10.2 Department Chairperson recommendation after receiving the application from the Medical Staff Services Department: thirty (30) days

5.10.3 Credential Committee recommendation after receiving the application from the Medical Staff Services Department: sixty (60) days

5.10.4 Medical Executive Committee recommendation after receiving the application from the Credentials Committee: thirty (30) days

5.10.5 Board of Directors after receiving recommendation from Medical Executive Committee: at next regular meeting

5.11 Reapplication after Adverse Decision

Unless otherwise provided for in the notice of a final adverse decision regarding

appointment/membership renewal, an applicant receiving a final adverse decision regarding appointment/ membership renewal shall not be eligible to reapply to the Medical Staff following the adverse decision. Adverse decisions do not include decisions based on hospital affiliation or location of office/residence. Individual consideration will be given to impaired physicians in accordance with Medical Staff, and Ohio State Medical Board policies and relevant Hospital policies.

5.12 Membership Renewal

5.12.1 Application for Membership Renewal

At a regularly specified time, each Medical Staff member receives an application for membership renewal from the Medical Staff Services Department. The application shall request or include:

(a) all information necessary to update and evaluate the qualifications of the applicant, including continued education, training and experience;

(b) physical and mental health status;

(c) name and address of any health care organization and practice setting where applicant has provided clinical services;

(d) evidence of liability insurance coverage in the amount required by the Board of Directors upon the recommendation of the Medical Executive Committee;

(e) information regarding limitation, restriction, suspension, or revocation of the practitioner's professional license;

(f) information regarding modification, suspension or revocation of the practitioner's DEA registration;

(g) information regarding restriction, relinquishment, or revocation of staff membership and/or privileges at another institution;

(h) information regarding any disciplinary action taken against the practitioner by any hospital, institution, or professional society;

(i) information regarding any professional liability judgments or settlements since the last renewal of membership;

(j) information regarding drug or alcohol addiction;

(k) clinical activity level of the practitioner at this Hospital; and

(l) participation in Medical Staff, Department, and committee activities and other staff activities at this Hospital.

The application will also provide an opportunity for the practitioner to:

(i) request membership renewal;

(ii) review present staff category;

(iii) request change in staff category, as appropriate;

(iv) request an addition to or a deletion from specified clinical privileges; and

(v) reaffirm by signature that the practitioner will abide by the Medical Staff Bylaws, Rules and Regulations, and Hospital policies.

5.12.2 Route of Completed Application

When a staff member submits a complete membership renewal application or submits a complete application for modification of staff category or clinical privileges, the member shall be subject to an in depth review generally following the procedures set forth in these Bylaws for initial applicants in Sections 5.5 through 5.10 with review of the following additions:

(a) the member-specific morbidity and mortality data, as compared with aggregate data;

(b) participation in continuing educational activities; and

(c) where there is insufficient data regarding the privileges requested, peer recommendations.

In the event that an applicant for membership renewal is the subject of an investigation or hearing at the time membership renewal is being considered, an extension of privileges may be granted pending the completion of the investigation and any related hearing process, in the discretion of the Medical Executive Committee and the Board of Directors. The Medical Executive Committee's evaluation shall be based exclusively on Medical Staff peer review criteria, adopted consistent with these Bylaws.

5.12.3 Failure to File a Membership Renewal Application

Failure to file a completed membership renewal application at least ninety (90) days prior to the expiration of the current membership term shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the current membership term. If within ninety (90) days the completed membership renewal application is received by the Medical Staff Services Department, the member may be considered for reinstatement.

5.13 Leave of Absence

Leave of absence, not to exceed one (1) year may be obtained upon written notice to the Medical Executive Committee. During the period of the leave, the staff member's clinical privileges, prerogatives, and responsibilities are inactive and cannot be exercised. At least sixty (60) days prior to the termination of the leave, or at any earlier time, the member may request reinstatement of clinical privileges, prerogatives, and responsibilities by submitting a written notice to that effect to the Medical Staff Services Department for transmittal to the MEC. The member may be required to submit evidence of continued and current clinical competence, of adequate physical and mental health status, and of good standing of licensure, DEA registration, and liability insurance which would be verified by the Medical Staff Services Department before being reviewed by and acted upon by the MEC and the Board of Directors. Failure of the member to request reinstatement or to return after the leave period ends, or

failure to make application for extension of the leave, shall constitute voluntary resignation from the Medical Staff.

A one-time extension of an original leave of absence may be requested, not to exceed one (1) year or the remainder of the membership term, whichever is shorter and accompanied by recommendation of the MEC. Failure to reapply after the one (1) year extension shall constitute a voluntary resignation after which time an initial application request is required.

5.14 Resignation

A Medical Staff member may resign from the staff upon written notice to the Medical Staff President and the President of the Hospital via the Medical Staff Services Department. Resignation will be accepted with the understanding by the resigning member that all responsibilities must be fulfilled prior to the resignation taking effect. These responsibilities include, but are not limited to, completion of all medical records for which the member is responsible and fulfillment of any outstanding financial obligations to the Medical Staff.

ARTICLE VI
CLINICAL PRIVILEGES

6.1 Exercise of Privileges

Every practitioner practicing at this Hospital shall be entitled to exercise only those clinical privileges specifically requested and granted consistent with these Bylaws. Said privileges must be hospital specific, within the scope of his/her license, certificate or other legal credential authorizing practice in this state, and shall be subject to the Bylaws, Rules and Regulations of the clinical department and the Medical Staff and subject to the approval of the Board of Directors.

6.2 Request for Privileges

Each membership application to the Medical Staff must contain a request for any specific clinical privileges desired by the applicant. A request by a Medical Staff member for a modification of clinical privileges may be made at any time, but such request must be supported by documentation of additional training and/or experience supportive of the request.

6.2.1 Consultation(s) will be required when the patient care needs exceed the clinical privileges of the practitioner(s) currently attending the case.

6.3 Basis for Privileges Determination

6.3.1 Determination of initial clinical privileges shall be applied uniformly to all applicants and shall be based upon the practitioner's education, training, experience, current licensure, health status, and demonstrated current competence as recommended by the Department Chairperson, and with the consideration of practice standards in the community. Privilege determination shall also be based on pertinent information concerning clinical performance and results of quality management activities obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges.

6.3.2 Clinical privileges are reassessed for each practitioner biannually, taking into account the practitioner's continued demonstration of professional competence, licensure, and adequate health status, as well as the results of Quality Management activities in the Hospital.

6.4 Dentists/Oral Surgeons/Podiatrists

Requests for clinical privileges from dentists, oral surgeons and podiatrists shall be subject to Sections 6.1 through 6.3 of this Article. Surgical procedures performed shall be under the overall supervision of the Chairperson of the Department of Surgery. All dental/oral surgery and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services with a physician member of the Medical Staff responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization. A dental/oral surgery or podiatric patient admitted to the Hospital must have a history and physical exam provided by a physician who has such privileges pursuant to these Bylaws and the Rules and Regulations of the Department and the Medical Staff. Dentists are responsible for that part of the history and physical exam related to dentistry. Podiatrists are responsible for that part of the history and physical exam related to podiatry. Qualified oral surgeons, subject to delineation and if granted such privileges, may perform the history and physical exam on oral surgery patients, and may assess the medical risks of the proposed

surgical procedures. Dentists/oral surgeons and podiatrists may write orders in the patient's chart in accordance with scope of licensure and the Rules and Regulations of the Department of Surgery and the Medical Staff.

6.5 Psychologists

Requests for clinical privileges from psychologists shall be subject to Sections 6.1 through 6.3 of this Article. All diagnostic or treatment services for mental or emotional disorders or any other service that legally may be performed by psychologists shall be under the overall supervision of the Chairperson of the Department of Medicine. Psychologists are not permitted to admit patients to the Hospital.

6.6 Allied Health Professionals

Requests for clinical privileges by Allied Health Professionals shall be subject to Sections 6.1 through 6.3 of this Article and Section 4.10 of Article IV.

6.7 Temporary Privileges

6.7.1 Circumstances

Upon written recommendation of the Chairperson of the department where the privileges will be exercised and the Medical Staff President, the Hospital President may grant temporary privileges for a period of time not to exceed ninety (90) days in the following circumstances:

(a) to an applicant to the Medical Staff upon receipt of a complete application for Medical Staff membership which includes a request for specific temporary privileges, and after verification of current licensure, DEA registration, adequate professional liability insurance coverage, relevant training or experience, ability to perform the privileges requested, lack of current or past successful challenge to licensure, no involuntary termination of Medical Staff membership at another organization, no involuntary limitation, reduction, denial, or loss of clinical privileges, and upon the basis of verbal references available which may reasonably be relied upon as to the current competence and ethical standing of the applicant and evaluation of the applicant’s National Practitioner Data Bank information. The temporary privileges may be granted for a period of time not to exceed the time during which the application is pending; OR

(b) to a practitioner who has not applied for membership on the Medical Staff but has been asked to care for a specific patient to fulfill an important patient care, treatment and service need, but only after receipt of a request from the patient's attending physician, verification of current licensure, a copy of DEA registration, verification of adequate professional liability insurance coverage, and receipt of available verbal references which may reasonably be relied upon as to the competence and ethical standing of the applicant; OR

(c) to a practitioner for a specified time period to cover a service or practice (locum tenens) to fulfill an important patient care, treatment and service need, but only after receipt of an application for specific temporary privileges, verification of current licensure, DEA registration, adequate professional liability insurance coverage, and upon the basis of verbal

references which may reasonably be relied upon as to the competence and ethical standing of the practitioner.

6.7.2 Termination of Temporary Privileges

The Hospital President may, at any time, after consultation with the Chairperson of the Department concerned or the Medical Staff President, terminate temporary privileges effective as of the discharge of the practitioner's patients. If it is determined that the life or health of the practitioner's patient(s) or any person might be imminently endangered by continued treatment by the practitioner, summary suspension may be imposed pursuant to Article XI of these Bylaws. In the event of such summary suspension, the Department Chairperson or Medical Staff President shall, in consultation with the Chief Medical Officer or the Hospital President, assign a member of the Medical Staff to assume responsibility for the care of the terminated practitioner's patients. The wishes of the patient(s) shall be considered where feasible in the selection of the substitute practitioner.

6.7.3 A practitioner shall not be entitled to the procedural rights afforded by Articles XII and XIII because a request for temporary privileges is refused.

6.8 Emergency Action Without Privileges

For the purposes of this section, an "emergency" is defined as a condition in which serious or permanent harm may result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment may add to that danger. In the case of an emergency, any Medical Staff member to the degree permitted by his/her license, and regardless of department, Medical Staff status, or clinical privileges, shall be permitted and assisted in taking action to save the life of a patient, using every necessary facility at the Hospital. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. Such request shall be made to the Hospital President, and must be approved by the Medical Staff President and the Chairperson of the department concerned. In the event such privileges are denied or the practitioner does not request such privileges, the Department Chairperson or President of the Medical Staff shall assign a member of the Medical Staff to assume responsibility for the care of the patient.

6.9 History and Physicals Privileges

Only those granted privileges to do so conduct history and physicals or update histories and physicals. Privileges to conduct a history and physical or an update to a history and physical are granted only to:

6.9.1 Physicians

Privileges to conduct or update histories and physicals may be granted upon request to qualified physicians who are members of the Medical Staff or seeking temporary privileges.

6.9.2 Oral/maxillofacial surgeons

Privileges to conduct or update histories and physicals only for those patients admitted solely for oral/maxillofacial surgery, consistent with the time requirements stated in this section may be granted upon request to qualified oral/maxillofacial surgeons who are members of the Medical Staff or seeking temporary privileges. For dentists and podiatrists refer to Section 6.4.

6.9.3. Allied Health Practitioners

Privileges to conduct or update histories and physicals may be granted to Allied Health Practitioners (e.g., advance practice nurses, physician assistants, or certified nurse midwives) as allowed by their State of Ohio licensure.

6.9.4 Residents/Interns

Participants in an approved graduate medical education program at the Hospital may conduct or update histories and physicals per the policies set by the program as approved by the MEC.

Every patient receives a history and physical within twenty-four (24) hours of admission, unless a previous history and physical performed within thirty (30) days of admission is on record, in which case that history and physical will be updated within twenty-four (24) hours of admission. Every patient admitted for surgery must have a history and physical within twenty-four (24) hours prior to surgery, unless a previous history and physical performed within thirty (30) days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four (24) hours prior to[(1)] surgery.

6.10 Disaster Privileges

6.10.1 Declaration of Emergency

The Hospital President, or designee, must declare an emergency and activate the Disaster Plan before disaster privileging may begin. The command center officer, based on the disaster or P.I.C.E. event, may recommend to the staging officer appointment of a coordinator of volunteer practitioners. All volunteer practitioners shall report to staging.

6.10.2 Immediate Credentialing

The Hospital President (or designee), the Chief Medical Officer, the Medical Staff President (or designee) or physician member of the Disaster Committee, at their discretion, may grant emergency privileges to qualified practitioners consistent with the Hospital's Disaster Plan, upon presentation of a valid photo identification issued by a state or federal agency and at least one of the following:

(a) A current hospital photo ID card;
(b) A current license to practice with valid photo ID issued by a state, federal, or regulatory agency;
(c) An ID indicating the volunteer is a member of a state or federal disaster medical assistance team (Disaster Medical Assistance Team ID);
(d) An ID from a municipal, state, or federal entity granting authority to administer patient care in emergency circumstances; or
(e) Presentation of the practitioner by a Hospital/Medical Staff member with personal knowledge of the practitioner's identity.

A file shall be made for each volunteer, including dates and times of arrivals and departures. All documents shall be photocopied and the copies shall be placed in the volunteer's file. The name of any hospital or Medical Staff member who has vouched for the volunteer shall also go in the file.

6.10.3 Scope of Privileges

The volunteer shall be granted an expansive scope of privileges on an emergency basis for his/her specialties. The coordinator of volunteer practitioners shall assign tasks consistent with the hospital's immediate needs.

6.10.4 Precautionary Measures

If possible, volunteers shall be paired with a practitioner who has privileges at St. John Medical Center, preferably in the same specialty. Practitioners who have been paired with volunteers shall immediately report any concern regarding the volunteer's competence to the coordinator of volunteer practitioners. The name of the practitioner with whom the volunteer was paired shall go in the volunteer's file. A decision based on information obtained regarding the professional practice of the volunteer will be assessed as soon as possible, but within seventy-two (72) hours, to determine the continuation of disaster privileges initially granted.

Volunteers shall wear position vests for the benefit of hospital and Medical Staff. The coordinator of volunteer practitioners shall disseminate lists of volunteers and their disaster privileges to all departments as time allows.

6.10.5 Short-term, After-the-Fact Credentialing

While the volunteer has begun to treat patients, Medical Staff Services shall verify the volunteer's hospital affiliation and licensure through telephone and internet communications, if possible. Medical Staff Services also shall attempt to check the National Practitioner Data Bank (NPDB) and Office of the Inspector General (OIG) sanctions list. Primary source verification of licensure is to be completed within seventy-two (72) hours from the time the volunteer practitioner presents to St. John Medical Center. If extraordinary circumstances prevent primary source verification of licensure within seventy-two (72) hours, there must be documentation of why primary source verification could not be performed in the required time frame; evidence of demonstrated ability to continue to provide adequate care, treatment and services; and an attempt to rectify the situation as soon as possible

6.10.6 Termination of Disaster Privileges

A volunteer's disaster privileges may be terminated at any time without reason or cause by the Hospital President (or designee), the Chief Medical Officer, the Medical Staff President (or designee) or a physician member of the Disaster Committee. The declaration by the Hospital President that the emergency is over will automatically terminate all disaster privileges. Termination of disaster privileges shall not give rise to appeal rights under the Medical Staff Bylaws or any other authority.

6.10.7 Long-term, After-the-Fact Credentialing

After the immediate emergency situation is under control, Medical Staff Services shall verify current competence and licensure for all volunteers, as if the volunteer were receiving temporary privileges, if it has not already done so. Medical Staff Services shall report any irregularities to the Chief Medical Office/Senior Vice President for Clinical Affairs. Medical Staff Services shall complete credentialing for volunteers no longer than three months after the emergency is declared to be over.

6.11 Exclusive Contracts

6.11.1 Newly Created Exclusive Contracts

When Hospital enters into a contract with a physician or group of physicians to provide services delivered under clinical privileges on an exclusive basis, such contracts shall not be deemed to revoke or limit the privileges of any member previously privileged to provide the service (an "Exempt Member"). To the extent that any such contract confers the exclusive right to perform specified services at a Hospital, no new applicant not included in such contract may be granted clinical privileges to perform the specified services while the contract is in effect, provided this shall not prevent privileging of up to two additional physicians who are employed by the same group practice that employs the Exempt Member at the time that the exclusive contract is created, but only for so long as the Exempt Member retains clinical privileges.

6.11.2 Existing Exclusive

If a newly created exclusive contract with one physician or group of physicians replaces an already existing exclusive contract with another physician or group of physician, then all members that were participating in the exclusive contract that is to be replaced lose those privileges they had held exclusively under that contract, and, unless they hold or apply for other privileges, their Medical Staff memberships. That member whose exclusive contract was replaced will not be entitled to any other procedural rights with respect to the decision or the effect of the new contract on his/her clinical privileges, unless the basis of the decision would entitle the member to hearing rights under these Bylaws, notwithstanding any other provision of the Bylaws. Notwithstanding the foregoing, the Hospital President may waive such automatic termination of privileges and membership if continuation of privileges or membership is in the best interest of the Hospital and its patients. A termination of privileges under this Section 6.11 shall not be reportable to the National Practitioner Data Bank or the State Medical Board of Ohio as an adverse action.

6.12 Special Temporary Privileges for Training Purposes

6.12.1 To a practitioner who has not applied for membership on the Medical Staff but who is enrolled in a program approved by the Medical Executive Committee and Board at the hospital to train practicing physicians in specific procedures which will be performed under the direct supervision of a physician with privileges to perform those specific procedures at the hospital.

6.12.2 To a Board eligible/certified physician who desires additional training / experience / fellowship.

In addition, receipt of the following items is required:

(a) A completed application for the program;

(b) A form completed by a hospital at which the practitioner currently has privileges or from a training program confirming that the physician is in good standing at that hospital and that the hospital has obtained primary source verification of the practitioner's current license and malpractice

insurance. For practitioners just completing training, proof of completion of a residency training program; and

(c) Results of a query of the National Practitioner Data Bank.

6.12.3 Shall not exceed the time frame set forth in the Medical Executive Committee and Board approved training program protocol.

6.12.4 Completion of this training does not entitle the trainee to privileges at St. John Medical Center (SJMC). Accordingly, should the practitioner seek Medical Staff membership / privileges at SJMC in the area he/she completed training, he/she shall be required to meet all requirements of the Bylaws and Rules & Regulations in effect at the time and as amended from time to time.

6.13 Membership/No Clinical Privileges

Courtesy Staff members seeking Medical Staff membership without clinical privileges may request "refer and follow privileges." They are exempt from all peer review (FPPE/OPPE) requirements. Current Active or Senior Medical Staff members holding such status prior to April 1, 2020, may request membership without clinical privileges at any time. Active Staff members would be exempt from volume requirements but must comply with Active Staff attendance requirements.

6.13.1 Prerogatives:

6.13.1(a) Practitioners with refer and follow privileges MAY:
Visit referred patients during hospitalization
Review patient record
Consult with attending physician

6.13.1(b) Practitioners with refer and follow privileges MAY NOT:
Direct treatment or assume responsibility for patient management
Supervise resident physicians
Document in the patient record

6.14 Telemedicine Privileges

6.14.1 Definitions

6.14.1.1 Telemedicine: The use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

6.14.1.2 Telemedicine privileges: Any licensed independent practitioner who has either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services through a telemedicine link) is credentialed and privileged according to this Section 6.14.

6.14.1.3 Originating site: site where the patient is located at the time the service is provided.

6.14.1.4 Distant site: the site where the practitioner providing the professional

service is located.

6.14.2 Services: The Medical Staffs at both the originating and distant sites recommend in writing the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites, consistent with commonly accepted quality standards.

6.14.3 Credentialing and privileging standards:

6.14.3.1 Hospital as originating site:

6.14.3.1.1 Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site via one of the following mechanisms:

6.14.3.1.1.1 Hospital fully credential and privilege the practitioner according to Section 3.2 of these Bylaws, or;

6.14.3.1.1.2 practitioner may be privileged for procedures performed via telemedicine link at the Hospital using credentialing information from the distant site if the distant site is Joint Commission-accredited.

6.14.3.1.1.3 out of state practitioners may obtain a telemedicine certificate from the State Medical Board of Ohio according to §4731.296 in lieu of full licensure to practice medicine and surgery in the State of Ohio. The telemedicine certificate holder is subject to all requirements of § 4731.296.

6.14.3.1.2 Retains responsibility for overseeing safety and quality of services offered to its patients.

6.14.4 Term of Privileges: A practitioner may be granted telemedicine privileges for a maximum period of two years, according to the staggered appointment schedule of the clinical department where telemedicine privileges are granted. Renewal of telemedicine privileges may be requested by the Chairman, subject to the procedures in Section. 5.12 of these Bylaws or practitioner may be privileged for procedures performed via telemedicine link at the Hospital using credentialing information from the distant site if the distant site is Joint Commission-accredited. Unless renewed, telemedicine privileges will automatically be terminated on the last day of the approved privileges period.

ARTICLE VII
CLINICAL DEPARTMENTS AND DIVISIONS

7.1 General Organization

The Medical Staff shall be organized into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chairperson selected and entrusted with the authority, duties, and responsibilities specified in Section 7.7. A department may be further organized, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief entrusted with the authority, duties, and responsibilities specified in Section 7.8. When appropriate, the MEC may recommend to the Medical Staff the creation, elimination, modification, or combination of departments and divisions.

7.2 Current Departments and Divisions

7.2.1 Department of Anesthesiology
Divisions:
(a) Anesthesia
(b) Critical Care
(c) Pain Management

7.2.2 Department of Cardiology
Divisions:
(a) Electrophysiology
(b) General Cardiology
(c) Interventional Cardiology

7.2.3 Department of Emergency Medical Services

7.2.4[8] Department of Medicine
Divisions[7]:
(a) Allergy and Immunology
(b) Dermatology
(c) Endocrinology
(d) Family Medicine[8]
(e) Gastroenterology
(f) Internal[8] Medicine
(g) Hematology/Oncology
(h) Infectious Diseases
(i) Nephrology
(j) Neurology
(k) Pediatrics[8]
(l) Psychiatry
(m) Pulmonary Medicine
(n) Radiology and Nuclear Medicine[8]
(o) Rehabilitation Medicine
(p) Rheumatology

7.2.5[8] Department of Orthopaedic Surgery

7.2.6[8] Department of Surgery
Divisions:
(a) Cardiothoracic Surgery
(b) Dentistry/Oral Surgery
(c) General Surgery
(d) Neurosurgery
(e) Obstetrics and Gynecology[8]

(f) Ophthalmology
(g) Otolaryngology and Head and Neck Surgery
(h) Pathology and Laboratory Medicine[8]
(i) Plastic Surgery
(j) Podiatry
(k) Urology
(l) Vascular Surgery

7.3 Assignments to Departments and Divisions

Each member of the Medical Staff shall be assigned membership in a department, and, if any, in a division which most closely resembles the medical discipline of the member's expertise. A Medical Staff member may be granted clinical privileges in other departments/divisions consistent with clinical privileges granted on the Medical Staff. Each voting staff member shall have voting privileges in only one department.

7.4 Criteria to Establish a Department/Division

Guidelines for creating or eliminating departments and divisions shall be established by the Medical Staff but shall minimally include the number of Active Staff practitioners in that specialty actually practicing at the Hospital, and their availability in sufficient numbers to carry out the required functions of a department/division.

7.5 Functions of Departments

The general functions of each department shall include:

7.5.1 Identification of the important aspects of care for the Department, selection of indicators used to monitor the quality and appropriateness of care, and determination of the data to be collected for evaluation and evaluation of quality and appropriateness of care. At a minimum, departments, through the appropriate Practice Committees, shall collect and evaluate department members'

(a) Operative and other clinical procedure(s) performed, if any, and their outcomes;
(b) Pattern of blood and pharmaceutical usage;
(c) Patterns of tests or procedures ordered;
(d) Patterns of length of stay and use of consultants; and
(e) Morbidity and mortality data.

In addition, each department shall add and update department-specific criteria annually for ongoing peer review of department members;

7.5.2 Establishing criteria for the granting of clinical privileges and the performance of specified services within the department;

7.5.3 Recommending CME programs pertinent to departmental clinical practice;

7.5.4 Meeting as often as necessary, but at least quarterly for the purpose of conducting the business of the department and considering performance improvement activities; and

7.5.5 Formulating recommendations for department Rules and Regulations reasonably necessary for the proper discharge of the department's responsibilities, subject to

the approval of the MEC and the Board of Directors.

7.6 Functions of Divisions

Each division shall perform the functions delegated to it by the Department Chairperson, subject to the approval of the MEC. Such functions may include, without limitation, quality review, evaluation of patient care practices, credentials review and privilege delineation, and continuing medical education programs. The division shall transmit regular reports to the Department Chairperson on the conduct of its delegated functions in accordance with procedures outlined in these Bylaws.

7.7 Department Chairpersons

7.7.1 Qualifications

Each Department Chairperson shall demonstrate the following requirements:

(a) Active or Senior Staff member;

(b) certified in his/her specialty, where certification exists;

(c) have the licensure, training and experience to oversee all clinical practice in the Department; a limited licensed practitioner would not be eligible;

(d) does not hold another office on this Medical Staff nor a similar position on any other staff or be employed by another hospital system; and

(e) member of the Medical Staff for at least three (3) years.

7.7.2 Selection

Department Chairpersons shall be elected at the fourth quarter Department meeting in odd-numbered years by secret ballot of the voting members of the department with a simple majority of votes required for election. Elected Department Chairperson shall assume office January 1. If no qualified candidate is identified who is willing to serve, a vacancy shall be deemed to exist which shall be filled as provided in Section 7.7.4.

7.7.3 Term of Office

Each Chairperson shall serve a two (2) year term and is eligible to succeed himself/herself but may not serve more than two consecutive complete terms.

7.7.4 Vacancy

When a vacancy occurs, the Medical Staff President will appoint a member of the department to fill the vacancy with approval of the MEC.

7.7.5 Removal

Removal may be initiated by the recommendation of the MEC, the Board of Directors or by petition signed by one-third (1/3) of the voting members of the Department. Removal shall be considered at a special meeting of the Department called for that purpose. A recommendation to remove the Chairperson shall require

a two-thirds (2/3) vote of the department members eligible to vote, but is not final unless passed by a two-thirds (2/3) vote of the MEC.

7.7.6 Responsibilities

The responsibilities of the Department Chairperson include, but are not limited to:

(a) act as presiding officer at department meetings;

(b) represent the department on the MEC;

(c) enforce the Bylaws, Rules and Regulations within the department;

(d) generally monitor and strive to continuously improve the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process;

(e) be accountable to the MEC for all professional and administrative activities in the department, and particularly for the quality of patient care rendered by members of the department;

(f) recommend delineated clinical privileges for each member of the department;

(g) transmit to the MEC and the Credentials Committee recommendations concerning practitioner appointment / reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to practitioners with clinical privileges in the department;

(h) appoint Division Chiefs, subject to approval of the MEC;

(i) appoint such committees as are necessary to conduct the functions of the department;

(j) designate another departmental member to be responsible for the department in his/her absence; this may be the previous department chairperson;

(k) assess and recommend to the MEC off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;

(l) integrate the department, and coordinate its services, with other departments and services;

(m) develop and implement policies and procedures that guide and support the provision of care, treatment, and services in the department and its divisions;

(n) recommend to the MEC a sufficient number of qualified and competent persons to provide care, treatment, and services in the department;

(o) determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(p) support the orientation and continuing education of all persons providing

care through the department;

(q) recommend space and other resources needed by the department; and

(r) carry out other responsibilities as established in these Bylaws or as are appropriately assigned by the President or MEC.

7.7.7 Chairpersons of Hospital-based Departments

The Chairpersons of the Hospital-based departments (Anesthesiology, Emergency Medical Services, Pathology and Radiology) shall be selected in accordance with contractual arrangements with the Hospital where such contracts exist. If the selected chairperson is not a member of the Active Staff, the selected chairperson will automatically be advanced to the Active Staff status and must maintain the qualifications to meet that category for the term of his/her office. The term of office may be indefinite.

7.8 Division Chiefs

7.8.1 Qualifications

Each Division Chief shall be a member of the Associate or Active Staff; a member of the division; certified in his/her specialty, where certification exists; and shall be qualified by training, experience, and demonstrated current competence in the clinical area covered by the division.

Any qualification may be waived, with the recommendation of the MEC, if qualified members of the division are unwilling and/or unable to serve.

7.8.2 Selection

Division Chiefs shall be appointed by the Department Chairpersons with consultation of members of the division, and approval of the MEC.

7.8.3 Term of Office

Each Division Chief's term of office shall coincide with that of the Department Chairperson. There is no limitation to the number of successive terms the Division Chief may serve. The Division Chief shall take office on January 1.

7.8.4 Vacancy

Vacancies in the office of Division Chief shall be filled in the same manner as the original selection.

7.8.5 Removal

A Division Chief may be removed for cause by the Department Chairperson with the approval of the division and the MEC.

7.8.6 Responsibilities

Each Division Chief shall:

(a) act as presiding officer at division meetings and transmit minutes of division business to the department chairperson;

(b) assist in the development and implementation, in cooperation with the department chairperson, of programs to carry out the quality review, evaluation, and monitoring functions assigned to the division;

(c) evaluate the clinical work performed in the division;

(d) conduct investigations as assigned and submit reports and recommendations to the department chairperson regarding the clinical privileges to be exercised within the division by members of or applicants to the Medical Staff; and

(e) perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chairperson or the MEC.

ARTICLE VIII
OFFICERS

8.1 Identification

8.1.1 The Officers of the Medical Staff shall be the President, Vice-President, Immediate Past President, and Secretary-Treasurer.

8.1.2 Other officials of the Medical Staff include Department Chairpersons and elected at-large members of the Medical Executive Committee. A maximum of six (6) at-large members may be elected. Three (3) at most shall be surgery/surgical subspecialties and three (3) at most shall be medicine/medical subspecialties.[8]

8.2 Qualifications

8.2.1 The Officers must be members of the Active or Senior Staff at the time of their election and must remain members in good standing during their term of office.

8.2.2 Candidates for President and Vice-President shall have demonstrated competence, interest, availability and organizational skills, as well as a reputation for objectivity and fairness.

8.2.3 Officers shall not hold two (2) offices simultaneously.

8.2.4 Officers shall not serve concurrently as Department Chairpersons.

8.2.5 Officers shall not concurrently hold office on the Medical Staff of any other hospital or be employed by another hospital system.

8.3 Nominations

8.3.1 The nominating committee shall select one or more nominees for each office to be filled.

8.3.2 Nominations may be made by petition provided that the name of the candidate is submitted in writing to the Chairperson of the Nominating Committee, is endorsed by the signature of at least ten (10) Medical Staff members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the Chairperson of the Nominating Committee no later than thirty (30) days prior to the October Quarterly Staff meeting.

8.3.3 Nominations will not be accepted from the floor.

8.4 Election

8.4.1 Officers and at-large members of the MEC shall be elected at the October Quarterly Staff meeting each even-numbered year by those members eligible to vote.[8]

8.4.2 Voting shall be by secret ballot. Absentee ballots may be requested in writing by a member eligible to vote if he/she cannot attend the October Quarterly Staff meeting due to a conflict with a yearly meeting of a national professional association or academy. The request may be made once the official ballot is finalized and must include proof of registration to the national meeting. The absentee ballot must be returned to the Medical Staff Services Department by the last mail delivery on the

day of the election. The absentee ballot will consist of an anonymous ballot as detailed in Article 15.3.2 of these Bylaws.(5)

8.4.3 A nominee shall be elected upon receiving a simple majority (fifty percent {50%} plus one {1}) of valid votes cast. If no candidate receives a majority vote on the first ballot, a runoff election shall be held immediately between the two candidates receiving the highest number of votes. Absentee ballots will only be valid for the first ballot. The second ballot will include only those members who are eligible to vote who are present at the meeting.(5) In case of a tie on the second ballot, the tie shall be broken by lottery.

8.5 Term of Office

Each officer and at-large member shall serve a two (2) year term commencing on January 1 following election. All officers and at-large members are eligible to serve two (2) consecutive terms. After serving two (2) consecutive terms, one (1) year must pass before an officer or at-large member is eligible to be re-elected to the same office.

8.6 Vacancies

8.6.1 Vacancies in office occur upon death, disability, resignation, removal or loss of membership on the Medical Staff.

8.6.2 When a vacancy occurs in the office of President, the Vice-President shall immediately assume the duties of the President and shall serve the remainder of the unexpired term.

8.6.3 When a vacancy occurs in the office of Vice-President, the President will appoint an ad hoc nominating committee, and a Vice-President will be elected to the unexpired term at the next Quarterly Staff meeting.

8.6.4 When a vacancy occurs in the office of Secretary-Treasurer, the MEC will appoint a qualified Active or Senior Staff member to serve the unexpired term.

8.6.5 When a vacancy for an at-large member of the MEC occurs, the Medical Staff President will appoint an Active or Senior Staff member to fill the vacancy for the unexpired term. If an insufficient number of at-large members are elected, the Medical Staff President may appoint an Active or Senior Staff member to fill the vacancy for that term. All at-large member appointments shall be approved by the MEC.(8)

8.7 Recall of Officers or At-Large Member

In the event an elected officer or at-large member does not strive to perform the leadership responsibilities and duties as defined in Section 8.8, or if his/her professional conduct and ethical behavior is not consistent with those sought for leading the Staff or Department, or does not uphold those of a leader as expected by the Medical Staff, as representative of the hospital in the community, the officer or at-large member may be removed from office.

Except as otherwise provided, recall of a Medical Staff Officer or at-large member may be initiated by majority vote of the MEC or shall be initiated by a petition signed by at least one-third (1/3) of the members of the Medical Staff eligible to vote for the officers, or by the recommendation of the Board of Directors. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the Medical

Staff members eligible to vote for officers who actually cast votes at the special meeting in person or by mail ballot.

8.8 Duties

8.8.1 President

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

(a) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

(b) serving as Chairperson of the Medical Executive Committee with vote;

(c) serving as an ex officio member of all other Medical Staff committees without vote, unless his/her membership on a particular committee is required by these Bylaws;

(d) interacting with the Hospital President in all matters of mutual concern within the Hospital and acting as liaison between the Medical Staff and Hospital Administration with timely and objective communications;

(e) appointing, in consultation with the MEC, committee members for all standing, special, and multi-disciplinary committees, except where otherwise provided by these Bylaws;

(f) working in conjunction with the Board of Directors and the administration of the Hospital to maintain the Hospital's licensing and accreditation;

(g) being a spokesperson for the Medical Staff in external professional and public relations;

(h) enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated and promoting compliance with procedural safeguards where corrective action has been requested or initiated; and

(i) attending meetings of the Board of Directors reporting on pertinent activities of the Medical Staff.

8.8.2 Vice-President

The Vice-President shall:

(a) assume all duties and authority of the President in the absence of the President;

(b) be a member of the MEC with vote;

(c) serve as a member of the Medical Staff Performance Improvement Committee and as a member of the Credentials Committee;

(d) attend meetings of the Board of Directors; and

(e) perform such other duties as are reasonably assigned by the Medical Staff President.

8.8.3 Immediate Past President

The Immediate Past President shall:

(a) be a member of the MEC with vote;

(b) serve as Chairperson of the Nominating Committee;

(c) perform such other duties as may be reasonably assigned by the Medical Staff President.

8.8.4 Secretary-Treasurer

The Secretary-Treasurer shall:

(a) be a member of the MEC with vote;

(b) assure the maintenance of a current roster of members;

(c) be responsible for accuracy and completeness of minutes of all MEC and Medical Staff meetings;

(d) call special meetings on the order of the Medical Staff President;

(e) attend to all appropriate notices and correspondence on behalf of the Medical Staff;

(f) receive and safeguard all funds of the Medical Staff;

(g) coordinate the bookkeeping and the accounting of the Medical Staff Fund to remain in compliance with Internal Revenue Service requirements;

(h) pay all bills as authorized;

(i) chair the Finance Committee; and

(j) perform such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Medical Staff President or the MEC.

ARTICLE IX
COMMITTEES

9.1 Designation

The Medical Staff committees shall include the MEC and such standing and special committees of the staff as may be necessary and desirable to perform Medical Staff functions. Unless otherwise specified, the Chairperson and Medical Staff members of all committees shall be appointed by the Medical Staff President with the approval of the MEC. Unless otherwise specified, hospital employee members of Medical Staff committees shall be appointed by the Hospital President in consultation with the Medical Staff President. Medical Staff committees shall be responsible to the MEC.

9.2 General Provisions

9.2.1 Term

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.

9.2.2 Removal

A Medical Staff committee member may be removed by the Medical Staff President, subject to approval of the MEC.

9.2.3 Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which original appointment to such committee was made.

9.2.4 Meetings

Unless otherwise specified, a Medical Staff committee established to perform one (1) or more of the Staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned functions, but no less than quarterly.

9.2.5 Reporting

Proceedings of all committee meetings, with the exception of the Nominating Committee, will be duly recorded as meeting minutes, approved by the committee Chairperson, and submitted to the MEC.

9.2.6 Functions

Medical Staff committees conduct business and accomplish the functions required of the Medical Staff. These functions shall include, but not be limited to, evaluation or review of:

(a) Medical Staff quality management
(b) Surgical cases
(c) Drug usage

(d) Blood usage
(e) Medical records
(f) Infection prevention and control
(g) Disaster control
(h) Bylaws
(i) Continuing medical education activities
(j) Credentialing
(k) Nominations
(l) Medical Staff Review
(m) Physician Utilization Review
(n) Utilization of Osteopathic Principles and Methods
(o) Others

The composition, responsibilities and functions of standing Medical Staff committees are set forth in these Bylaws. Ad hoc committees can be established by the MEC as needed. Evidence that the above functions are being effectively accomplished shall be documented by reports to the MEC and in MEC reports to the Board of Directors.

9.3 Bylaws Committee

9.3.1 Composition

At least four (4) members of the Active, Senior or Emeritus Staff with one (1) designated as Chairperson.

9.3.2 Term

Members shall serve a minimum term of one (1) year.

9.3.3 Meetings

The Bylaws Committee shall meet as needed, but at least biannually.

9.3.4 Responsibilities

Maintain up-to-date Medical Staff Bylaws, proposing changes as needed;

Maintain up-to-date Medical Staff Rules and Regulations, proposing changes as needed;

Provide interpretation of Bylaws as necessary; and

Report to the MEC for information and action.

9.4 Cancer Committee

9.4.1 Composition

Composition of the committee shall be multidisciplinary and must include physician representatives from general surgery, medical oncology, radiation oncology, pathology, diagnostic radiology, the American College of Surgeons Cancer Liaison Physician[6], and such other specialty physicians representing the major cancer experience(s) at St. John Medical Center. One (1) member shall be designated

Chairperson. Non-physician committee members include representatives from oncology nursing, administration, social services or case management, cancer registry, quality management, palliative care[6], and other support services as deemed necessary.

9.4.2 Term

Members shall serve a minimum term of one (1) year, once appointed members may serve indefinitely unless otherwise notified.[3]

9.4.3 Meetings

The Cancer Committee shall meet as often as necessary but at least quarterly.[6]

9.4.4 Responsibilities

Responsible and accountable for all cancer program activities at St. John Medical Center;

Designates one coordinator for each of the six (6)[3] areas of Cancer Committee activity: cancer conference, quality control of cancer registry data, quality improvement, community outreach, clinical research, and psychosocial services[3];

Sets goals; plans, initiates, implements, evaluates, and develops strategies to improve all cancer related activities[3];

Establishes subcommittees or workgroups as needed to fulfill cancer program goals;

Establishes guidelines related to Cancer Conference or Tumor Board[6] to include but not limited to frequency, format, and multi-disciplinary attendance[3];

Monitors and evaluates the Cancer Conference frequency, multidisciplinary attendance, total number of [6] case presentations and percentage[6] of prospective case presentations, discussion of stage, eligibility for clinical trial enrollment and adherence to cancer conference policies[6] on an annual basis;

Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis. The plan includes procedures to monitor case finding, accuracy of data collection (especially the accuracy of Collaborative Staging), abstracting timeliness, follow-up and data reporting;

Completes site-specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the Medical Staff;

Reviews fifteen[6] percent (15%) of the analytic caseload to monitor physician use of AJCC staging or other appropriate staging, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning for cancer patients;

Each required member or designated alternative attends at least seventy-five percent (75%) of the Cancer Committee meetings held each calendar year. [6]

Reviews ten percent (10%) of the analytic caseload to ensure that ninety-five[(6)] percent (95%) of the cancer pathology reports include all[(6)] data elements as outlined in the CAP protocols;

Annually, a physician member of the Cancer Committee performs a study to assess whether SJMC patients are evaluated and treated according to evidence-based national treatment guidelines[(3)];

Monitors the quality of patient care using each of the Commission on Cancer (CoC) quality reporting tools at least annually;

Provides a formal mechanism to educate patients about cancer-related clinical trials;

Monitors the effectiveness of the[(6)] Community Outreach activities each calendar year[(6)];

Offers one (1) cancer-related educational activity each year to physicians, nurses, and other allied health professionals. This activity[3] relates to the use of AJCC staging, or other appropriate staging, other site specific prognostic indicators and evidence based national treatment guidelines in planning treatment for cancer patients;

Completes and documents the required studies that measure quality and outcomes with at least two (2) studies[(6)] serving as the basis for a quality improvement[(3)];

Implements two (2) improvements that directly affect cancer[(6)] patient care; and

Reports activities to the MSPIC and MEC for information and action.

9.5 Cardiology Practice Committee

9.5.1 Composition

The Committee Members shall include the Cardiology Department Chair, Division Chiefs, Medical Directors within the Department and other Department members as appointed by the Medical Staff President. Ex-officio (non-voting) members include Administrative and Quality Representatives and other support staff as needed.

9.5.2 Term

Committee Medical Staff members shall serve a minimum term of one (1) year.

9.5.3 Meetings

The Department of Cardiology Practice Committee shall meet as often as necessary but at least quarterly[(3)] as part of the departmental meetings.

9.5.4 Responsibilities

Administer the processes designed to support quality care and patient safety creating a culture of continuous improvement as identified in the Department Rules and Regulations, as adopted by the Department of Cardiology, by monitoring, evaluating and reevaluating performance measurements, clinical reviews and

quality improvement as defined in the Department Quality Plan;

Review the Department Quality Plan, appropriateness of procedures (indication and technique), proposals for adopting new procedures or techniques, and peer review of all procedure related mortalities and cases with sufficient adverse outcomes as defined in the Department of Cardiology Quality Plan;

Identify potential problems or trends and define corrective action;

Evaluate at every meeting (on a rolling rotation per the matrix approved within the Quality Plan) outcome measurements reported from participation in key databases core measures as required by appropriate professional societies; and

Report the results of quality activities and recommended actions based on identified areas for improvement to the Department of Cardiology and the MEC.

9.6[7] Credentials Committee

9.6.1 Composition

The Credentials Committee shall be composed of six (6) members of the Active, Senior or Emeritus Staff representing six (6) different departments. The Vice Medical Staff President shall be a member of this committee.

9.6.2 Term

Members shall serve a minimum term of one (1) year.

9.6.3 Meetings

The Credentials Committee shall meet no less than ten (10) times per year. If there is no application to review or other business to transact, a monthly meeting may be cancelled at the discretion of the Chairperson.

9.6.4 Responsibilities

Review all initial applications for appointment to the Medical Staff and for clinical privileges as delineated in Article V of the Bylaws;

Review all applications for Medical Staff membership and for renewal of clinical privileges referred to in Article V of the Bylaws;

Review all requests for modification of clinical privileges as referred to in Article VI of the Bylaws;

Review and respond to all questions regarding clinical privileges or credentials of any practitioner on the Medical Staff; and

Report results of the above activities to the MEC.

9.7[7] Critical Care Committee

9.7.1 Composition:

Medical Directors of ICU, CCU and Emergency Department; Chairpersons of appropriate Medical Staff Departments or their designees. Co-Chairs are the Medical Directors of the ICU and the Emergency Department.[7] Non-voting: Unit Managers of ICU, CCU and Emergency Department; House Physicians as needed; Vice President for Patient Care Services or designee; and a Medical Staff Services representative.

9.7.2 Term

Members shall serve a minimum term of one (1) year.

9.7.3 Meetings

The Critical Care Committee shall meet as often as necessary but[3] at least quarterly.

9.7.4 Responsibilities

Facilitate the smooth functioning of the Emergency Department, the Coronary Care Unit and the Intensive Care Unit through discussion and problem solving;

Coordinate patient care with the Operating Room and Recovery Room when a Critical Care Unit is involved;

Provide quality management monitoring and evaluation activities for the Critical Care Units;

Initiate, review and implement policies and protocols as needed; and

Report results of above to the MSPIC and MEC for information and final action.

9.8[7] Finance Committee

9.8.1 Composition

At least three (3) members of the Active, Senior or Emeritus Staff, in addition to the Medical Staff Treasurer, who chairs the Committee.

9.8.2 Term

Members shall serve a minimum term of one (1) year.

9.8.3 Meetings

The Finance Committee shall meet as often as necessary but at least biannually.[3]

9.8.4 Responsibilities

Prepares the budget for Medical Staff operations;

Oversees the budget and disbursals from Medical Staff funds;

Oversees preparation of tax filing, financial statements, audits and other

appropriate service of the Medical Staff's accountant; and

Recommends dues rates to the Medical Executive Committee.

9.9(7) Joint Conference Committee

The Joint Conference Committee shall be an ad hoc committee created upon action by the Board of Directors. The President of the Medical Staff may request that the Board of Directors create the Joint Conference committee at any time, which request may be addressed at the next regularly scheduled meeting of the Board of Directors. For purposes of clarity, the Joint Conference Committee shall not be a committee of the Board of Directors and shall not have the authority to take any action on behalf of the Board of Directors. Unless otherwise designated in the resolution of the Board of Directors establishing the Joint Conference Committee, the following provisions shall apply:

9.9.1 Composition

The Medical Staff President and two (2) current Medical Staff officers selected by the Medical Staff President and an equal number of Board members who are neither Medical Staff members nor Hospital employees.

9.9.2 Term

Members shall serve for the duration of the existence of the Joint Conference Committee unless such committee is in existence for more than one (1) year, in which case, the members of the Joint Conference Committee shall each have a term of one (1) year.

9.9.3 Meetings

The Committee shall meet at as needed to address the issue(s) that gave rise to the creation of the Joint Conference Committee.

9.9.4 Responsibilities

The responsibilities of the Joint Conference Committee shall be those set forth in the resolution establishing the Joint Conference Committee. If the responsibilities are not set forth therein, the responsibilities of the Joint Conference Committee shall be the forum in which the Medical Staff and Board resolve any disputes and may accept requests to resolve differences between or among other Medical Staff and/or Hospital leaders. The committee may request additional information from throughout the Hospital community to assist in the resolution of disputes.

9.10(7) Medical Executive Committee

9.10.1 Composition

(a) Voting Members: President; Immediate Past President; Vice President; Secretary-Treasurer; two (2) At-large members of Active Staff, at least one (1) of whom is a D.O.; and Chairpersons of the Medical Staff Departments

(b) Ex-Officio (non-voting): Hospital President; the Chief Medical Officer; Vice President, Patient Care Services; and Chairpersons of Medical Staff Committees.

9.10.2 Term

Members of the MEC shall serve a term equal to the term of their elective office.

9.10.3 Meetings

The MEC shall meet at least monthly and shall maintain a record of its proceedings. The MEC must meet quorum requirements as stated in Section 10.3.4.

9.10.4 Responsibilities

The responsibilities of the MEC are:

(a) representing and acting on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

(b) receiving and acting upon reports and recommendations of and coordinating activities of departments, divisions, and committees;

(c) establishing in the Medical Staff Bylaws the structure of the Medical Staff;

(d) establishing the organization of quality management activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities;

(e) assisting in maintaining Hospital accreditation and informing the Medical Staff of the accreditation status of the Hospital;

(f) establishing in the Medical Staff Bylaws the mechanism to review credentials, performance, competence, and character of both new applicants and Medical Staff members, and making recommendations to the Board of Directors regarding clinical privileges, membership assignments to departments, and corrective action including membership termination as necessary;

(g) establishing and ensuring the mechanism for fair hearing procedures and the termination of Medical Staff membership is in place, and followed as outlined in Articles XI, XII, and XIII;

(h) participating in review of infection prevention and control, internal and external disaster plans, hospital safety, and utilization review;

(i) accounting to the Board of Directors for the overall quality and efficiency of patient care in the Hospital;

(j) Evaluates resource allocation on an interdepartmental basis; and recommends changes in staffing, space and other hospital resources as needed to support privileges for which criteria have been developed through the Medical Staff sections, departments and Medical Executive Committee; and

(k) fulfilling other responsibilities as established by these Bylaws.

The Medical Staff can remove the Executive Committee's delegated authority temporarily, as appropriate to protect the Medical Staff's interests, by vote of at least two-thirds (2/3) of all voting members. To remove the delegated authority, a meeting may be called by submitting a request to the Medical Staff President endorsed by the signature of at least ten (10) Medical Staff members who are eligible to vote. The Medical Staff President shall call a special meeting of the Medical Staff, which shall be scheduled within thirty (30) days after receipt of such request. The meeting notice shall include the stated purpose of the meeting and mailed to all voting members at least seven (7) days prior to the meeting, or, in an emergency, not less than forty-eight (48) hours in advance by telephone or electronic transition (including, but not limited to, facsimile or electronic mail) prior to the date of the meeting. No business shall be conducted at the meeting except that stated in the notice calling the meeting. If the required vote cannot be obtained, the majority of voting members present may elect to either withdraw the petition or to request a mail ballot. If mail ballot is approved, the procedure for a mail ballot as defined in Article 15.3.2 shall be followed but requiring a two-thirds (2/3) vote for approval.

9.11[(7)] Nominating Committee

9.11.1 Composition

The Nominating Committee shall be composed of the Immediate Past President, who shall serve as Chairperson, and four (4) other members of the Active or Senior Staff, no two (2) of whom shall be from the same department. Each Department shall select one (1) eligible member at the second quarter Department meeting as a candidate for election to the Nominating Committee. The departmental candidates will be voted on at the July Quarterly Staff Meeting by those members of the Medical Staff who are eligible to vote. The four (4) candidates receiving the most votes will comprise the committee along with the Immediate Past President.

9.11.2 Term

Members of the Nominating Committee shall serve a term from the date of election through the end of the same year.

9.11.3 Meetings

The Nominating Committee shall hold a sufficient number of meetings to fulfill the responsibilities as stated below.

9.11.4 Responsibilities

Selection of one (1) or more qualified nominees for each office to be filled, including nominees for at-large members of the MEC;

Transmission of the slate of nominees by mail to the members of the Medical Staff eligible to vote at least sixty (60) days prior to the October Quarterly Staff Meeting; and

Review nominations by petition to determine whether they meet the requirements of these Bylaws.

9.12[7] Obstetrics and Gynecology Practice Committee

9.12.1 Composition

All members of the Department of Obstetrics and Gynecology, one (1) of whom shall be designated Chairperson.

9.12.2 Term

Members shall serve a minimum term of one (1) year.

9.12.3 Meetings

The Obstetrics and Gynecology Practice Committee shall meet as often as necessary but[3] at least quarterly.

9.12.4 Responsibilities

Identify potential problems or trends involving the Department and report to the Department Chairperson;

Monitor, evaluate, and re-evaluate quality care provided by practitioners and ancillary services; and

Refer recommendations to the Department Chairperson and the MEC for action.

9.13[7] Operating Room Committee

9.13.1 Composition

Chairperson of the Surgery (who chairs the committee), Anesthesia, OB/GYN and Orthopaedics Departments; and designees of each Surgery Department Division. Non-voting members are appropriate designees of each of the following nursing staffs: Surgery, Recovery Room, Outpatient Surgery, and Vice President of Patient Care Services/Director of Nursing

9.13.2 Term

Members shall serve a minimum term of one (1) year.

9.13.3 Meetings

The Operating Room Committee shall meet as often as necessary but at least biannually.[3]

9.13.4 Responsibilities

Identify potential and present trends or problems involving practitioners and the functions/ equipment of the operating room;

Report to the Surgery Department recommended action based on identified areas for improvement;

Report quality issues reviewed regarding problems identified for action/recommendation;

Review reports regarding the quality and appropriateness of patient care; and

Report results of above to the MEC for information and final action.

9.14[7] Pharmacy, Nutrition and Therapeutics Committee

9.14.1 Composition

At least five (5) Medical Staff members, one (1) of whom shall be designated Chairperson, and the Director of Pharmacy and non-voting representatives from Nursing and Administration.

9.14.2 Term

Members shall serve a minimum term of one (1) year.

9.14.3 Meetings

The Pharmacy and Therapeutics Committee shall meet as often as necessary but[3] at least quarterly.

9.14.4 Responsibilities

To serve in an advisory capacity to the Medical Staff and Hospital administration in all matters pertaining to the use of drugs (including investigational drugs);

To develop a formulary of drugs accepted for use in the Hospital and provide for its constant revision;

To establish programs and procedures that help ensure cost-effective drug therapy;

To establish or plan suitable educational programs for the Hospital's professional staff on matters related to drug use;

To participate in quality assurance activities related to distribution, administration, and use of medications;

To review adverse drug reactions in the Hospital;

To initiate and/or direct drug use review programs and studies and review the results of such activities;

To advise the pharmacy in the implementation of effective drug distribution and control procedures;

To make recommendations concerning drugs to be stocked in Hospital patient care areas; and

Report results of above to the MSPIC and the MEC for final action.

9.15[7] Social Committee

9.15.1 Composition

The Social Committee shall be composed of at least three (3) members of the Medical Staff.

9.15.2 Term

Members shall serve a minimum term of one (1) year.

9.15.3 Meetings

The Social Committee shall meet as often as necessary to perform the responsibilities described below.

9.15.4 Responsibilities

To plan the major social functions of the Medical Staff, i.e., the annual golf outing and the annual clambake.

9.16[7] Tissue and Surgical Practice Committee

9.16.1 Composition:

Members shall include representatives of the Department of Surgery to include the surgical subspecialties, (one {1} of whom shall be designated Chairperson); and a representative of the Department of Pathology.[2]

9.16.2 Term

Members shall serve a minimum term of one (1) year.

9.16.3 Meetings

The Tissue and Surgical Practice Committee shall meet as often as necessary but[3] at least quarterly.

9.16.4 Responsibilities

Review all removed tissue (subspecialties to be consulted as needed depending upon the issue of specialty being reviewed). In a questionable case, the committee should consult the appropriate physician in regard to his/her surgical decision. In addition, the appropriate physician also has a right to request such a meeting;
Receive reviews, actions and recommendations from the divisions reporting to the Department of Surgery for action;

Monitor, evaluate and re-evaluate quality of care provided by physicians, specialty units and ancillary services;

Formulate and record conclusions after review of each case and report findings and recommendations to the Department of Surgery Chairperson for action;

Identify potential problems or trends involving the appropriate department and

report to the appropriate Department Chairperson for approval or non-acceptance; if approved, forward to MEC;

Review tissues with minimum or no pathology to determine the justification for the surgical procedures performed; and

Members shall not review their own charts or those of others who may have contractual relationships with them.

9.17[7] Trauma Performance Improvement and Patient Safety (PIPS) Committee[1]

9.17.1 Composition

Composition of the committee shall be multidisciplinary and must include the trauma surgeons, orthopaedic, neurosurgical, anesthesia, and Emergency Medicine physician representatives. The physician representatives must participate in the hospital's ED call rotation for their specialty. The Chairperson shall be the Trauma Medical Director. Non-physician committee members include the trauma coordinator and representatives from administration, nursing (ED/OR/ICU), radiology and other support services as deemed necessary.[1]

9.17.2 Term

Members shall serve a minimum term of one (1) year.[1]

9.17.3 Meetings

Although the meeting is usually held monthly, the frequency will be determined by the Trauma Medical Director based upon the needs of the program. Members must attend a minimum of 50% of meetings to comply with American College of Surgeons' Committee on Trauma requirements.[1]

9.17.4 Responsibilities[1]

Encompasses both the peer review component and the operations of the Trauma program;[1]

Continuously monitors the processes and providers that impact the care of the trauma patient population;[1]

Reviews operational issues and processes;[1]

Identifies and resolves non-clinical problems which impact the Trauma program;[1]

Measures to evaluate patient care, processes and outcomes include Trauma registry data, evidence based guidelines, pathways and hospital protocols;[1]

Evaluates[1]

- Compliance/variance from established guidelines/protocols and pathways;
- Appropriateness of pre-hospital and Emergency Department I triage;
- Delay(s) in diagnosis;
- Delays in OR availability/equipment;
- Communication/judgment errors
- Timeliness of lab and x-ray studies;

- Professional behavior;
- Mortality;
- Morbidity;
- Length of stay; and
- Cost

Establishes subcommittees or workgroups as needed to fulfill trauma program goals; and[1]

Reports activities to the Department of Surgery for information and action.[1]

9.18[7] Wellness Committee

9.18.1 Composition

At least three (3) Medical Staff members, one (1) of whom has experience or interest in addiction/behavioral medicine, one (1) of whom shall be designated Chairperson. In the event no one with addiction/behavior medicine background is available, the Medical Staff President may select an outside physician to serve in this role on the committee as a consultant. No committee member is a department chair, member of the Credentials or Medical Executive Committees, or otherwise holds a leadership position with authority to limit or suspend a practitioner's privileges. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment/improvement committees while serving on this committee.

9.18.2 Term

Members shall serve a minimum term of two (2) years. Except for initial appointments, the term of each member shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity.

9.18.3 Meetings

The Wellness Committee shall meet as needed. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities to the Medical Executive Committee.

9.18.4 Responsibilities

Receives reports from any source regarding a member's possible impairment due to illness, injury, substance abuse or other physical or emotional condition, including self-referrals, and evaluates the credibility of a complaint, allegation or concern;

Refers members to the medical or surgical specialists, or other sources, for evaluation and treatment of condition affecting the member's ability to safely practice;

Assists members with post-evaluation and treatment monitoring. Referrals, monitoring and all member-related activity by the committee and its members is confidential; however, should a member fail to comply with treatment plans and monitoring or otherwise jeopardize patient safety, the committee refers the member to the Medical Executive Committee for corrective action; and

Organizes staff-wide education about professional impairment issues.

ARTICLE X
MEETINGS

10.1 General Staff Meetings

10.1.2 Regular/Annual Meetings

Regular meetings of the Medical Staff shall be held quarterly, with the Annual Meeting constituting the regular fourth quarter meeting. The date, time and place of the meetings shall be determined by the MEC, and adequate notice shall be given to members.

10.1.3 Order of Business and Agenda

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

(a) Acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

(b) Administrative reports from the Medical Staff President, the Hospital President, the Chief Medical Officer, departments, divisions and committees;

(c) Reports on overall results of quality review, evaluation, and monitoring activities of the staff by responsible officers, committees, and departments;

(d) Unfinished business;

(e) New business; and

(f) Exclusive to the Annual Meeting, the election of the Medical Staff officers will be held.

10.1.4 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Medical Staff President, the Hospital President, the Chief Medical Officer or at the request of the Board of Directors, the MEC, or upon the written request of ten (10) members of the Active Staff. The meeting shall be scheduled within thirty (30) days after receipt of such request. The notice of such meeting, which includes the stated purpose of the meeting, shall be mailed to all voting members at least seven (7) days in advance, or, in an emergency, not less than forty-eight (48) hours in advance by telephone or electronic transmission (including, but not limited to, email or facsimile) prior to the meeting date. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.2 Committee, Department and Division Meetings

10.2.1 Except as otherwise specified in these Bylaws, the chairpersons of committees, Departments and Divisions may establish the times and frequency of regular meetings; however, Departments shall meet no less than quarterly. The chairpersons shall make reasonable efforts to ensure the meeting dates are disseminated to the members with adequate notice. For purposes of membership

renewal, this section correlates with Section 10.6.2 of these Bylaws.

10.2.2 Special Meetings

A special meeting of any committee, Department or Division may be called by the chairperson thereof, the MEC, the Medical Staff President, the Board of Directors or by ten percent (10%) of each group's current voting members. No business shall be transacted at any special meeting except that stated in the meeting notice. Notice of such meeting shall be the same as in Section 10.1.4.

10.3 Quorum

10.3.1 Quorum Requirements for General Medical Staff and Special Meetings of the Medical Staff.

A quorum shall consist of the Senior and Active members present at any regular or special meeting of the Staff for the transaction of all business. For amendment of the Bylaws, see Article XV: Section 15.3

10.3.2 Quorum Requirements for Department & Division Meetings

For the conduct of business at a Department or Division meeting, a quorum shall consist of the Active, Associate and Senior members present.

10.3.3 Quorum Requirements for Committee Meetings

For the conduct of business at a Committee meeting, a quorum shall consist of the members present.

10.3.4 Quorum Requirements for the Medical Executive Committee

A quorum for the Medical Executive Committee shall consist of the presence of a minimum of fifty percent (50%) of voting members.

10.4 Manner of Action

Except for the purpose of amending these Bylaws or as may be otherwise specified in these Bylaws, the action of a simple majority (fifty percent {50%} plus one{1}) of the members present and voting at any meeting at which a quorum is present shall constitute the action of the entire group. Any 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 the required majority of the quorum. Action may be taken by a committee without a meeting if acknowledged by a written document setting forth the action so taken and signed by each member entitled to vote thereat.

10.5 Minutes

Except as otherwise specified in these Bylaws, minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved and signed by the presiding officer, forwarded to the MEC, and approved at a subsequent meeting by those in attendance. A permanent file of the minutes shall be maintained.

10.6 Attendance Requirements

10.6.1 All Active Staff members shall attend at least fifty percent (50%) of all general Medical Staff meetings duly convened pursuant to these Bylaws. In addition, all Active Staff shall attend at least fifty percent (50%) of department meetings or an aggregate of six (6) department/division/assigned committee meetings for one (1) year or an aggregate of twelve (12) department/division/assigned committee meetings for two (2) years.

10.6.2 Associate and Courtesy Staff members shall have no requirements to attend general Medical Staff or Department/Division meetings.[7]

10.6.3 Attendance at assigned committee meetings is encouraged for all members of the Medical Staff.

10.6.4 Committee membership appointments will be made by the Medical Staff President and subject to MEC approval, with consultation by the department chairperson or the committee chairperson. Members of the Active Staff shall be expected to serve on at least one committee if so appointed.

10.7 Conduct of Meetings

Unless otherwise specified in these Bylaws, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

10.8 Electronic Participation for MEC

Notice, attendance, and actions including voting and participation may be accomplished by internet communication, email or other electronic and/or telephonic means where permitted by the chair of the MEC meeting on either an individual or group basis.

ARTICLE XI
CORRECTIVE ACTION

11.1 Conduct

Medical Staff members shall continuously meet the requirements for professional conduct established in these Bylaws. Privileges holders will be held to the same conduct requirements as members.

11.1.1 Acceptable Conduct

Acceptable Medical Staff member conduct is not restricted by these Bylaws and includes:

(a) Advocating for patients;

(b) Providing recommendations or criticism intended to improve care;

(c) Exercising rights granted under the Medical Staff Bylaws, Rules and Regulations, and policies; and

(d) Fulfillment of duties of Medical Staff membership or leadership.

11.1.2 Disruptive and Inappropriate Conduct

Disruptive and inappropriate Medical Staff member conduct is conduct that affects or could affect the quality of patient care at the Hospital which takes the form of:

(a) Harassment, in the form of verbal, visual or physical abuse, by a Medical Staff member directed at another Medical Staff member, house staff, Hospital employee, contractor or volunteer, or patient on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex, or sexual orientation;

(b) Deliberate physical, visual or verbal intimidation or challenge, including threatening, pushing, grabbing or striking another person involved in the hospital;

(c) Carrying a gun or other weapon in the Hospital;

(d) Abuse of or refusal or failure to comply with these member conduct requirements;

(e) Physical assault or acts of violence, throwing of instruments, charts or other objects; and

(f) Retaliation, or threatening retaliation, as reprisal for reporting disruptive or inappropriate conduct.

11.1.3 Medical Staff Conduct Complaints

Complaints or reports of disruptive and inappropriate conduct by Medical Staff members are subject to review whether or not the witness or complainant requests

or desires action to be taken. Complaints or reports must be in writing, and will be transmitted to the Medical Staff President, the Hospital President and the Chief Medical Officer (or their respective designees). Complaints are shared with the subject member, who will be given the opportunity to respond to the officer or, if referred, the committee handling the complaint. The Medical Staff President shall refer the matter to the Wellness Committee for evaluation immediately if there is any indication that the member's health is implicated. The Medical Staff President and the Chief Medical Officer or the Hospital President shall confer to determine if the complaint or report is obviously specious or meritless and warrants no further action. If the Medical Staff President and the Chief Medical Officer or the Hospital President both agree that no action is warranted, the decision is reported at the next Medical Executive Committee in executive session, and may be discussed and acted upon at the request of any Medical Executive Committee member. Complaints not referred to the Wellness Committee or dismissed by the Medical Staff President and the Chief Medical Officer or the Hospital President are referred to the appropriate department for evaluation or to the Medical Executive Committee for consideration of investigation and corrective action under these Bylaws. To the extent practicable, complaints will remain confidential and, if requested by the complainant, anonymous.

11.1.4 Hospital Staff Conduct Complaints

Medical Staff members' reports or complaints about the conduct of any hospital administrators, nurses or other employees, contractors, Board members, volunteers or others affiliated with the Hospital who are not Medical Staff members must be presented in writing and submitted to the President or any Medical Staff officer. The Medical Staff President shall forward the complaint or report to the Chief Medical Officer or the Hospital President for action. Reports and complaints regarding Hospital staff conduct will be tracked through the Medical Staff Services Department, which will report actions or other results of such complaints to the Medical Executive Committee.

11.1.5 Abuse of Process

Retaliation or attempted retaliation against complainants or those who are carrying out Medical Staff duties regarding conduct will be considered inappropriate and disruptive conduct, and could give rise to evaluation and corrective action pursuant to the Medical Staff Bylaws. Abuse of this conduct process, in the form of repeated unsubstantiated or malicious complaints, is in itself inappropriate and disruptive behavior, and will result in corrective action under these Bylaws. Repeated baseless or malicious complaints by non-physician staff members of Hospital will be referred to the Hospital President or his/her designee.

11.2 Routine Corrective Action

11.2.1 Initiation of Routine Corrective Action

Any person may provide information to the Medical Staff President, the Hospital President or the Chief Medical Officer about the performance or competence of a Medical Staff member. When reliable information indicates a staff member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) contrary to Medical Staff Bylaws, rules or regulations; or (3) below applicable professional standards, a request for an investigation or action against such

member may be made by the Medical Staff President, the Hospital President, the Chief Medical Officer, the Department Chairperson or a Medical Staff committee.

A request for investigation or corrective action must be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request.

11.2.2 Investigation

The MEC acts on requests for investigation or initiates an investigation on its own action, making a record of the reasons. After deliberation, the MEC shall act on the request, by determining that investigation is not warranted or directing that an investigation be undertaken. The MEC may conduct the investigation itself, or may assign this task to an officer, department, or ad hoc or standing committee of the Medical Staff. The member subject to investigation shall promptly be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner the investigating body deems appropriate. This investigative process shall not constitute a hearing as that term is used in Article XII, nor shall procedural rules with respect to hearings apply. The investigating individual or group shall proceed in a prompt manner and shall forward a written report to the MEC as soon as practicable. Despite the status of any investigation, the MEC shall retain authority and discretion to terminate the investigative process at any time and proceed with action described in Section 11.2.3 after having the Chief Medical Officer or other Hospital President designee review the procedural aspects of the initiation and investigation for contemplated corrective action.

11.2.3 MEC Action

As soon as practicable after conclusion of the investigation, the MEC shall take action which may include, without limitation:

(a) recommending no corrective action is required;

(b) deferring action for a reasonable time, if warranted, but in any event, no longer than sixty (60) days from the referral;

(c) recommending a letter of warning, reprimand, admonition or censure;

(d) imposing terms of remediation in concurrence with the subject member, such as but not limited to, additional training, concurrent review of admissions or procedures, or proctoring;

(e) recommending reduction, modification, suspension, or revocation of clinical privileges;

(f) recommending reduction of staff category, or limitation of any staff prerogatives related to the practitioner's delivery of patient care;

(g) recommending suspension or revocation of Medical Staff membership; or

(h) taking other actions deemed appropriate under the circumstances.

11.2.4 Subsequent Action

(a) MEC actions as set forth in Section 11.2.3 (a), (b), (c), or (d), which are not reportable to the National Practitioner Data Bank, are not subject to hearing rights under Article XII or appellate review under Article XIII. Any such MEC actions, together with supporting documentation, shall be forwarded in writing to the Board of Directors.

If the MEC recommends an action under Section 11.2.3 (a), (b), (c), or (d), and the Board agrees with the action, then the MEC recommendation shall be final upon the Board's action and not subject to appellate review under Article XIII.

If the MEC recommends an action under Section 11.2.3 (a), (b), (c), or (d), and the Board disagrees and takes another action set forth in Section 11.2.3(a), (b) (c) or (d), then the action of the Board shall be final and not subject to appellate review under Article XIII.

If the MEC recommends an action under Section 11.2.3 (a), (b), (c), or (d), and the Board disagrees and finds that an action set forth in Section 11.2.3(e) through (h) may be warranted, then the Board may refer the matter to the President of the Medical Staff to be subject to a hearing under Article XII below, or the Board may take a final action, which shall be subject to appellate review under Article XIII below.

The practitioner shall be notified in writing of all final actions. The practitioner shall not have the right to a hearing for, or an appeal of a final action under Sections 11.2.3(a), (b), (c) or (d). For any decision of the Board of Directors that is contrary to the recommendation of the MEC, the Board may submit the matter to a joint committee of the Board of Directors and the Medical Staff for review and recommendation before making a final decision.

(b) An MEC recommendation or Board action that would be reportable to the National Practitioner Data Bank as set forth in Section 11.2.3 (e) through (h) shall be promptly transmitted to the practitioner via certified mail, return receipt requested. The practitioner shall then be entitled to a formal hearing as set forth in Article XII.

(c) Within the context of this Section, a modification or termination of clinical privileges shall not take effect until any hearings or appeals provided for in these Bylaws and requested by the practitioner have been completed.

11.3 Summary/Precautionary Suspension

11.3.1 Initiation of Summary/Precautionary Suspension

Whenever a practitioner's conduct, decisions or practice require that immediate action be taken to prevent imminent danger to the health and/or safety of any patient, employee, or other person in the Hospital or disrupts the delivery of patient care, the Medical Staff President, the chairperson of the practitioner's department (in consultation with the Chief Medical Officer), the Chief Medical Officer, or the Hospital President shall have the authority to summarily suspend all or any portion of the practitioner's clinical privileges. Such summary suspension shall become

effective immediately upon imposition. Notice of such suspension may be given verbally, but shall be followed within twenty-four (24) hours by written notice from the Hospital President or Chief Medical Officer sent via certified mail, return receipt requested. In the event of such suspension, the patients being treated by the individual under summary suspension shall be assigned to another practitioner by the department chairperson (in consultation with the Chief Medical Officer), the Chief Medical Officer or the Medical Staff President. The wishes of the patient(s) shall be considered, where feasible, in choosing a substitute practitioner.

The imposition or continuation of a summary suspension or restriction is a precaution only and does not, in and of itself, constitute a finding of fault on the part of the individual, and, accordingly, shall not be a reportable professional review action or give rise to hearing and appeal rights under these Bylaws, except as otherwise required by law.

11.3.2 MEC Action

The MEC shall investigate and convene to review and consider the summary suspension as soon as practicable, which is contemplated to be no later than twenty-one days from the date of the summary suspension. The affected practitioner may request to attend this meeting, but in no event shall this meeting constitute a hearing as provided for in Article XII. The MEC may modify, continue, or terminate the summary suspension. If the MEC immediately terminates the suspension, the practitioner's privileges shall be reinstated, and the practitioner so notified by the Medical Staff President or the Chief Medical Officer.

11.3.3 Procedural Rights

Should the MEC continue or modify the suspension, the practitioner shall be entitled to the procedural rights as provided in Article XII.

11.4 Automatic Suspension

11.4.1 Licensure

Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, or restricted, or the practitioner is placed on probation, then the practitioner's Medical Staff membership and clinical privileges shall be automatically revoked, suspended, or restricted, or the practitioner placed on probation in a similar manner as of the date such action becomes effective and throughout its term. Further action on the matter shall proceed pursuant to Section 11.4.6.

11.4.2 Drug Enforcement Agency (DEA) Certificate

Whenever a practitioner's DEA certificate is revoked, suspended, limited, or the practitioner is placed on probation, then the practitioner shall automatically be divested of the right to prescribe medications covered by the DEA certificate as of the date such action becomes effective and throughout its term. Further action on the matter shall proceed pursuant to Section 11.4.6.

11.4.3 Failure to Respond

Failure to respond to a relevant inquiry from a committee, Department Chairperson

or MEC related to this Article or other related provisions of these Bylaws, as specified in the Medical Staff Rules and Regulations shall result in automatic suspension of clinical privileges.

11.4.4 Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws.

11.4.5 Exclusion from Governmental Programs

Permissive or mandatory exclusion from Medicare, Medicaid or any other governmental health insurance program.

11.4.6 MEC Deliberation

As soon as practicable after automatic action is taken as described in Sections 11.4.1 through 11.4.5, the MEC shall convene to review and consider the facts. The MEC may recommend such further corrective action deemed appropriate or may rescind the suspension upon a showing that the suspension was implemented inappropriately. If membership is automatically suspended to the end of the membership term, or for six (6) consecutive months, the member shall be deemed to have voluntarily resigned the membership and/or the affected privileges, as applicable.

11.5 Medical Records Suspension

Members of the Medical Staff are required to complete medical records within such time as may be prescribed by the MEC and in accordance with policies approved by the MEC. Failure to complete medical records as specified in the Medical Staff Rules and Regulations may result in suspension of clinical privileges.

ARTICLE XII
HEARINGS

12.1 Grounds for Hearing

The following recommendations or actions shall, if deemed adverse pursuant to Section 12.2, entitle the practitioner affected thereby to a hearing:

12.1.1 Denial of initial Medical Staff membership when the application has been deemed a complete application;

12.1.2 Denial of renewed Medical Staff membership;

12.1.3 Suspension of Medical Staff membership;

12.1.4 Revocation of Medical Staff membership;

12.1.5 Denial of requested advancement in Medical Staff category, if such denial affects clinical privileges;

12.1.6 Reduction in Medical Staff category, if such reduction affects clinical privileges;

12.1.7 Denial of requested clinical privileges;

12.1.8 Involuntary reduction or restriction of clinical privileges;

12.1.9 Suspension of clinical privileges; or

12.1.10 Revocation of clinical privileges.

12.2 When Deemed Adverse

A recommendation or action listed in Section 12.1 shall be deemed adverse only when it would be reportable to the National Practitioner Data Bank and has been:

12.2.1 Recommended by the MEC; or

12.2.2 Taken by the Board of Directors contrary to a favorable recommendation by the MEC; or

12.2.3 Taken by the Board of Directors on its own initiative without prior recommendation by the MEC.

12.3 Exceptions to Hearing Rights

The following recommendations or actions do not entitle the practitioner to a hearing:

12.3.1 Voluntary relinquishment of clinical privileges;

12.3.2 Automatic suspension of clinical privileges as delineated in Section 11.4 or a suspension pursuant to Section 11.5;

12.3.3 Issuance of a verbal or written warning or reprimand; or

12.3.4 Any recommendation or action taken with respect to temporary privileges.

12.4 Notice of Adverse Recommendation/Action

A practitioner against whom an adverse recommendation or action has been taken by the MEC shall promptly be given written notice via certified mail, return receipt requested, by the Medical Staff President. The notice shall:

12.4.1 describe the recommendation or action;

12.4.2 state the reason(s) for the recommendation/action;

12.4.3 specify that the practitioner may request a hearing within fifteen (15) days after receiving the notice, delivering such request to the Medical Staff President either in person or by certified mail, return receipt requested;

12.4.4 state that failure to request a hearing within fifteen (15) days shall constitute a waiver of rights to a hearing and to appellate review on the matter; and

12.4.5 provide the practitioner a summary of his/her rights in the hearing as set forth in this Article.

12.5 Waiver of Hearing

If the practitioner fails to request a hearing within fifteen (15) days, and in the manner described in Section 12.4, then the practitioner shall be deemed to have waived any right to a hearing and to have accepted the recommendation or action which shall become effective immediately.

12.6 Request for Hearing

The practitioner shall have fifteen (15) days following receipt of the notice described in Section 12.4 to request a hearing. Such request shall be delivered to the Medical Staff President either in person or by certified mail, return receipt requested, to the Medical Staff Services Department.

12.7 Notice of Hearing/Medical Staff Review Committee

Upon receipt of a request for hearing, the Medical Staff President, in consultation with the Chief Medical Officer, shall nominate a Medical Staff Review Committee composed of no fewer than three (3), but not more than five (5), members of the Active, Senior or Emeritus Staff in good standing who have not actively participated in the consideration of the matter at any previous level. Nominees shall become members of the Medical Staff Review Committee upon appointment by the Hospital President. Knowledge of the matter involved shall not preclude a member of the Active, Senior or Emeritus Staff from serving as a member of the Medical Staff Review Committee. The members of the Medical Staff Review Committee may not be in direct economic competition with the practitioner; the fact that a member is employed by a particular practice group shall not, in and of itself, constitute direct economic competition. If a member of the committee is not a disinterested or impartial party for the purpose of the hearing, he/she shall disqualify himself/herself and the Medical Staff President shall nominate a replacement for consideration and appointment by the Hospital President. Individuals involved in peer review activities shall not have a personal economic interest in and/or a conflict of interest with the subject of the peer review activity. Impartial peer would exclude individuals with blood

relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance of the potential of bias for or against the subject of the peer review. In the event that it is not possible to name an impartial Medical Staff Review Committee from the Active, Senior or Emeritus Staff, the Medical Staff President may nominate qualified members of the Associate or Courtesy Staff for appointment by the Hospital President. As soon as possible, the Medical Staff Review Committee shall, through the Medical Staff President, notify the practitioner of the date, time, and place of the hearing via certified mail, return receipt requested. Reasonable efforts shall be used to set the hearing date between thirty (30) and forty-five (45) calendar days from the date of the request for hearing, unless an earlier date is requested by the practitioner and agreed to by the Committee. In addition, the notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, and list specific or representative charts in question and/or other reasons or subject matter which was considered in making the adverse recommendation.

12.8 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times allowed in this Article may be permitted by the Medical Staff Review Committee within its discretion on a showing of good cause, but not beyond what the Medical Staff Review Committee considers reasonable.

12.9 Failure to Appear

The personal presence of the practitioner who requested the hearing shall be required. Failure of the practitioner to appear shall be deemed to constitute a waiver of the right to a hearing and voluntary acceptance of the recommendations or actions involved which shall become effective immediately. In the case of a documented emergency preventing the appearance of the practitioner, the Presiding Official of the Medical Staff Review Committee shall have the option to reschedule the hearing.

12.10 Hearing Procedure

12.10.1 Medical Staff Review Committee

All members of the Medical Staff Review Committee shall be present at the hearing. If a member of the committee must be absent, the Medical Staff President shall nominate a member to substitute for the duration of the hearing process. Vacancies shall be filled upon appointment by the Hospital President following nomination by the Medical Staff President.

12.10.2 Representation

The affected practitioner shall be entitled to be accompanied and represented by a member of the Medical Staff in good standing and/or by an attorney of his/her choice or by any other individual of his/her choice. The Medical Executive Committee shall be represented by an appointed member of the Medical Staff and/or represented by an attorney of its choice.

12.10.3 Presiding Official

After consultation with the parties, the Hospital President or the Chief Medical Officer shall appoint a presiding official, who shall be an attorney licensed to practice law in the State of Ohio. The presiding official may not be in direct

economic competition with the practitioner involved. The presiding official shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants shall have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The presiding official shall not vote on any matters before the Medical Staff Review Committee, but may serve as counsel to the Medical Staff Review Committee and write the report of the Medical Staff Review Committee.

12.10.4 Rights of the Parties

During the hearing both the affected practitioner or his/her representative and the MEC representative shall have the right to:

(a) present evidence determined to be relevant by the presiding official, regardless of its admissibility in a court of law;

(b) rebut any evidence;

(c) bring in appropriate witnesses; be represented by an attorney, and examine their own witnesses and cross-examine witnesses presented by the other party; a witness list must be supplied by both parties to the Presiding Official of the Medical Staff Review Committee and to the other party at least one (1) week prior to the hearing;

(d) have a record made of the proceedings; and

(e) submit a written statement at the close of the hearing.

12.10.5 Procedure and Evidence

The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which reasonable persons customarily rely in the conduct of serious business shall be admitted, regardless of the admissibility of such evidence in a court of law.

It is intended that these Bylaws comply with the federal statute known as the "Health Care Quality Improvement Act" ("Act"), and any additional requirements or procedures contained in the Act will be considered to be included in these Bylaws and will be followed accordingly.

12.10.6 Burden of Proof

The MEC representative shall have the obligation to present prima facia evidence in support of the adverse recommendation or action. Once prima facia evidence supporting the recommendation or action is presented, the burden of proof shall shift to the affected practitioner by a preponderance of the evidence that the grounds lack any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable or capricious.

12.10.7 Record of Hearing

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

12.10.8 Recesses and Conclusion

The Medical Staff Review Committee may recess a hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing.

12.10.9 Recommendation and Report

The Medical Staff Review Committee may, at a time convenient to itself, conduct its deliberations outside the presence of the affected practitioner. As promptly as is reasonably practicable after final adjournment of the hearing, the Medical Staff Review Committee shall render a recommendation to the MEC which shall be accompanied by a written report setting forth the decision and specifying the reasons for it and shall also be delivered to the affected practitioner.

12.10.10 Recommendation by the MEC

Within thirty (30) days following the receipt of a recommendation by the Medical Staff Review Committee, the MEC shall consider the report and affirm, modify or reverse the recommendation. The recommendation of the MEC shall then be forwarded to the Board for action, which shall be accompanied by the report of the Medical Staff Review Committee. A copy of the MEC recommendation shall also be delivered to the affected practitioner.

12.10.11 Action of the Board

Within a reasonable time, but no event later than sixty (60) days, the Board shall consider the report and affirm, modify, or reverse the recommendation of the MEC. No later than fourteen (14) days after the date of considering the report, the Board shall notify the practitioner and MEC of its decision including, where applicable, notice to the practitioner of his/her right to seek appellate review of the decision. If the practitioner fails to request an appeal of the Board's decision in accordance with these Bylaws, then such decision becomes final and concludes the proceedings. In considering the MEC's recommendation, the Board shall have the discretion to engage expert assistance (whether in the form of outside reviewing physician expertise or otherwise) to assist in its decision-making process.

12.11 Reporting Corrective Actions to Related Hospitals

In the event formal corrective action is taken against a practitioner holding privileges at any facility owned in whole or in part by University Hospitals Health System ("UHHS") or by the Sisters of Charity of St. Augustine Health System ("CSAHS"), the Hospital shall be permitted to notify the President, Chief Medical Officer, and the Medical Executive Committee of such other facilities of such formal corrective action. No notice under this Section 12.10.11 shall be made until the practitioner has either waived or fully exhausted his/her fair hearing rights under these Bylaws.

ARTICLE XIII
APPELLATE REVIEW

13.1 Request for Appellate Review

Either the MEC or the practitioner shall have fifteen (15) days following receipt of a notice pursuant to Section 5.8.3 or 12.10.11 to request an appellate review. This request must be written and delivered to the Hospital President or the Chief Medical Officer via certified mail, return receipt requested, or in person. The request may also include a request for a copy of all written material pertaining to the hearing, favorable and unfavorable, which was used in making the adverse decision, as well as a copy of the hearing record and report.

13.2 Waiver by Failure to Request Appellate Review

A party who fails to request an appellate review within the fifteen (15) days and in the manner specified in Section 13.1, shall be deemed to have waived the party's right to such review and to have accepted the adverse decision.

13.3 Notice of Time and Place for Appellate Review

Upon receipt of a timely request for appellate review, the Chief Medical Officer or the Hospital President shall deliver such request to the Board of Directors. The Board shall schedule a date, time, and place for the review, such date not to be less than ten (10) nor more than forty-five (45) days from the date of receipt of the request for appellate review.

13.4 Appellate Review Body

The Board of Directors as a whole or a committee of the Board as appointed by the Chairperson of the Board or a committee appointed by the Board which may have Board members shall act as the appellate body. If a committee is appointed, one (1) of its members shall be designated as Chairperson.

13.5 Appellate Review Procedure

13.5.1 Presiding Official

The Chairperson of the appellate review body shall be the presiding official and shall determine the order of procedure, make all required rulings, and maintain decorum.

13.5.2 Nature of Proceedings

The proceedings of the review body shall be in the nature of an appellate review based upon the record of the hearing before the Medical Staff Review Committee and its report, and all subsequent results and actions thereon. The appellate review body shall also consider material submitted, if any, pursuant to Sections 13.5.3 through 13.5.5.

13.5.3 Written Statements

The parties may submit a written statement on their own behalf to the appellate review body through the Chief Medical Officer or the Hospital President at least three (3) days prior to the scheduled date for the appellate review. The statement may detail the findings of fact, conclusions and procedural matters with which the

parties disagree, and the reasons for such disagreement. The written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation.

13.5.4 Oral Statements

The appellate review body, in its sole discretion, may allow the parties or their representatives, which may be attorneys, to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the appellate review body.

13.5.5 Consideration of New Evidence

New or additional evidence not raised or presented during the original hearing nor included in the hearing report or record shall be introduced at the appellate review only at the discretion of the appellate review body following an explanation by the party requesting consideration of such evidence as to why it was not presented earlier.

13.5.6 Presence of Members and Vote

A majority of the appellate review body will be present throughout the review and deliberations. If a member of the review body is absent from any part of the proceedings, he/she will not be permitted to participate in the deliberations nor the decision.

13.5.7 Recess and Adjournment

The appellate review body may recess the review proceedings and reconvene same, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review will be closed. The appellate review body will, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of the deliberations a decision will be rendered to affirm, modify, or reverse the Medical Staff Review Committee recommendation and the appellate review will be declared finally adjourned.

13.6 Board of Directors Action

Within ten (10) days of receipt of the decision of the appellate review body, the Board of Directors will render its final decision. It may vote to affirm, reject, or modify the decision of the appellate review body. If the Board's decision is not consistent with the MEC recommendation, the Board may, at its option, refer the matter to a Joint Conference Committee consisting of equal of Board members and representatives of the MEC with a statement of the reasons for the decision. Such referral may include a request for a further hearing to resolve specified disputed issues. Within ten (10) days after the referral, the Joint Conference Committee will forward its recommendation to the Board of Directors, and the Board will render a final decision. The decision of the Board will be effective immediately and shall be final. The decision shall not be subject to further hearing or appellate review.

13.7 One Hearing and Appellate Review

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right

to more than one (1) hearing as described in Article XII and one (1) appellate review as described in this Article XIII with respect to an adverse recommendation or action.

13.8 Release

By requesting a hearing or appellate review pursuant to Articles XII or XIII, a practitioner agrees to be bound by the provisions of Article XIV relating to immunity from liability in all matters relating thereto.

ARTICLE XIV
CONFIDENTIALITY, IMMUNITY AND RELEASE

14.1 Authorization and Conditions

Any practitioner applying for or exercising clinical privileges at this Hospital:

14.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon the practitioner's professional ability and qualifications from any source, both during the credentialing and privileging process and throughout the duration of the practitioner's Medical Staff membership, provided such information is given or received in good faith and without malice;

14.1.2 Agrees to be bound by the provisions of this Article and to waive all legal claims against any Hospital or Medical Staff representative who acts in accordance with these Bylaws;

14.1.3 Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital; and

14.1.4 Agrees and acknowledges that Hospital may confidentially share information regarding privileging and corrective actions about the applicant with any other facility owned in whole or in part by UHHS or CSAHS.

14.2 Confidentiality

Information with respect to any practitioner which is collected, submitted, or prepared by any representative of this Medical Staff or Hospital, or by any other health care facility, organization or Medical Staff for the purpose of achieving and maintaining quality patient care shall be confidential to the fullest extent permitted by law and shall not be disseminated nor used in any way except as provided herein or except as otherwise required by law.

14.3 Immunity from Liability

14.3.1 For Action Taken

No authorized representative of the Hospital or Medical Staff shall be liable to a 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, if such representative acts in good faith and without malice.

14.3.2 For Providing Information

No authorized representative of the Hospital or Medical Staff and no third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to an authorized representative of this Hospital or Medical Staff or to any other hospital care facility or organization of health care professionals concerning such practitioner who is or has been an applicant to or a member of the Medical Staff or who did or does exercise clinical privileges or provide specified services at this Hospital, if such representative acts in good faith and without malice.

14.4 Activities and Information Covered

14.4.1 Activities

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

(a) Applications for membership, clinical privileges or specified services;

(b) Corrective action;

(c) Hearings and appellate reviews;

(d) Utilization reviews;

(e) Quality management activities;

(f) Claims reviews;

(g) Risk management reviews;

(h) Peer review organizations, State Medical Board and similar reports; or

(i) Other Hospital, department, committee or staff activities related to maintaining quality patient care and appropriate professional conduct.

14.4.2 Information

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

14.5 Releases

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article, subject to such requirements, including those of good faith, absence of malice, and the exercise of reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

14.6 Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protection provided by law and not in limitation thereof.

ARTICLE XV
REVIEW, ADOPTION, AMENDMENT AND EFFECT OF BYLAWS, RULES & REGULATIONS AND POLICIES

15.1 Biennial Review

The Medical Staff Bylaws, Rules and Regulations and Policies and Procedures are reviewed biennially (every two {2} years) by the Bylaws Committee. Revisions may be made at other times in accordance with the need of the Medical Staff to reflect current practices in its organization and function.

15.2 Adoption

These Bylaws, together with appended Rules and Regulations, shall be adopted as described in Sections 15.3 and 15.4, respectively. Upon adoption they shall replace any previous constitution or Bylaws and Rules and Regulations and shall become effective upon approval by the Board of Directors.

15.3 Amendment of the Bylaws

These amendment processes are the exclusive means of amending the Medical Staff Bylaws.

15.3.1 Development of Amendments

Amendments may be proposed in writing by any member of the Medical Staff or by the Bylaws Committee, the MEC, the Board of Directors, or at any regular meeting of the Medical Staff. The proposed amendment shall be referred to the Bylaws Committee for exact wording and for discussion of impact on any other section of the Bylaws. The Bylaws Committee shall forward its recommendation on the proposed amendment to the MEC for review. The proposed amendment, along with the recommendation of the MEC, shall be mailed to all members of the Medical Staff eligible to vote along with the notice of the next regular or special meeting of the Medical Staff. Such notice will be mailed a minimum of fifteen (15) days prior to the date of the regular meeting or a minimum of seven (7) days prior to the date of the special meeting. The proposed amendment will be discussed at that meeting. After which, voting on the proposed amendment(s) shall be conducted by mail ballot by those members eligible to vote. For the purpose of approving an amendment to the Bylaws, a fifty-one percent (51%) affirmative vote of eligible members is required.

15.3.2 Voting on Amendments

The mail ballot will consist of an anonymous ballot to be marked and then secured in an unmarked envelope. This will then be sealed in a return envelope on the back flap of which is the voter's printed name and signature. The signed return mail envelope will be sent to the Medical Staff Services Department.[5] A time limitation will be set for receipt of the ballots with at least two (2) weeks allowed, but no more than four (4) weeks from the date they are mailed out to voting members. As the ballots are received by the Medical Staff Services Department, the names will be checked against a list of all voting members. Only those ballots which have been handled according to the above procedure and whose names are legible will be counted. When the allowed time limit has expired, the envelopes will be opened in the presence of the tellers appointed by the Medical Staff President, and the inner

anonymous envelopes given to the tellers. The tellers will open and count the ballots and provide the totals for affirmative and negative to the Medical Staff President. A fifty-one percent (51%) affirmative vote of the eligible voting members is required for adoption of the proposed amendment. Members of the Medical Staff will be informed at the next scheduled Department meetings, with the understanding that an amendment approved by the Medical Staff will take effect only upon approval by the Board of Directors. If an insufficient number of ballots is returned to the Medical Staff Services Department by the expiration of the time limit, it will be deemed a rejection of the proposed amendment and the Medical Staff will be so informed.

15.4 Amendment of the Rules and Regulations

These amendment processes are the exclusive means of amending the Rules and Regulations.

15.4.1 Medical Staff

The Medical Staff shall initiate and adopt such Rules and Regulations as may be necessary to implement more specifically the principles in these Bylaws and for the proper conduct of its work. The Rules and Regulations are subject to the approval of the Board of Directors, which approval shall not be unreasonably withheld. The Rules and Regulations shall be reviewed periodically by the Bylaws Committee and be revised to comply with current Medical Staff practices. Changes may be proposed in writing by any Medical Staff member or by the Bylaws Committee, MEC, the Board of Directors or at any regular meeting of the Medical Staff. Changes to the Rules and Regulations recommended by the Bylaws Committee shall be reviewed and evaluated by the MEC prior to presentation to the Medical Staff as a whole. Any modification(s) to the change(s) made by the MEC will be referred to the Bylaws Committee to insure there is no conflict with the current Bylaws and Rules and Regulations prior to presentation to the Medical Staff. The Rules and Regulations may be adopted, amended or repealed at any regular or special meeting of the Medical Staff at which a quorum is present by a simple majority vote of those members present and eligible to vote. The proposed change shall be mailed to all members of the Medical Staff eligible to vote along with the notice of the next regular or special meeting of the Medical Staff. Such notice will be mailed a minimum of fifteen (15) days prior to the date of the regular meeting or a minimum of seven (7) days prior to the date of the special meeting at which the change will be considered. Such changes shall become effective when approved by the Board of Directors. If there is a conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail.

15.4.2 Departmental

Subject to the approval of the MEC, 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 not be inconsistent with these Bylaws, the Rules and Regulations of the Medical Staff or other policies of the Hospital.

15.5 Urgent Amendments Required by Law or Regulation

In cases of a documented need for an urgent amendment to Bylaws or Rules and Regulations necessary to comply with law, regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Directors may provisionally approve, an

urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Staff will be promptly notified of the provisional amendment by the MEC. The Medical Staff shall have the opportunity for retrospective review and comment on the provisional amendment at the next regularly scheduled meeting of the Medical Staff. If the Medical Staff approves the conditional amendment as written, the provisional amendment shall be final. If the Medical Staff modifies the provisional amendment, the modified amendment shall be handled in accordance with Section 15.3 or 15.4 above. Any conflicts between the Medical Staff and the MEC regarding the amendment shall be resolved in accordance with Section 15.6 below.

15.6 Process to Manage Conflicts

Conflicts between the Medical Staff and the MEC with regard to the adoption or amendment of a provisions of the Bylaws, the Rules and Regulation or policy established under these Bylaws shall be referred to the Medical Staff President, who shall use his/her best efforts to resolve the conflict after obtaining relevant evidence and positions of the parties in conflict prior to submission to the Board of Directors. If the conflict is not resolved, the version of the Bylaws, Rules and Regulations or policy adopted by the Medical Staff shall be submitted to the Board of Directors along with a description of the conflict and alternative version. The Board may request additional information regarding the conflict before acting on the proposal. The version approved by the Board shall be final.

15.7 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff membership**,** delineation of clinical privileges, corrective action, notice, and other matters shall be subject to approval by the MEC.

15.8 Construction of Terms and Headings

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

15.9 Authority to Act

Any member who acts in the name of the Medical Staff without proper authority shall be subject to such disciplinary action as deemed appropriate by the MEC.

15.10 Transmittal of Reports

Reports and other information which these Bylaws require to be submitted to the Board of Directors by the Medical Staff shall be deemed so transmitted when delivered, unless otherwise specified, to the Hospital President.

15.11 Notices

Except where specific notice provisions are otherwise provided in these Bylaws, any notices or other informational matter to be mailed shall be sent through the U.S. Mail, first class, or by an alternative where such has proven reliable and expeditious. Notice to the Medical Staff, Medical Staff officers or Medical Staff committees shall be addressed as follows:

Name of addressee
Name of Department or Committee
c/o Medical Staff Services Department

St. John Medical Center
29000 Center Ridge Road
Westlake, Ohio 44145

Mailed notices to a member, applicant, or other party shall be to the addressee at the address as it appears in the official records of the Medical Staff or the Hospital.

15.12 Medical Staff Policy

The MEC shall develop and adopt policies that are binding upon the Medical Staff and its members and those otherwise holding clinical privileges. Such policies must be consistent with the Medical Staff Bylaws, Rules and Regulations. Policies adopted by the Medical Executive Committee and Hospital policies relevant to the Medical Staff are binding upon the Medical Staff and its members. Amendments to Medical Staff policies are to be distributed in writing to Medical Staff members and those otherwise holding clinical privileges in a timely and effective manner.

RULES AND REGULATIONS
OF THE
MEDICAL STAFF
OF
UH ST. JOHN MEDICAL CENTER

Approved
at the
Voting Staff Meeting
December 4, 1991

Approved
by the
Board of Directors
December 12, 1991

Revision Dates:
May 10, 1996
October 22, 2002
February 16, 2007
May 18, 2007
October 14, 2008
May 14, 2010
November 19, 2010
June 28, 2013[1]
December 8, 2015[2] (approved March 25, 2016)
May 19, 2017[3]
October 20, 2017[4]
September 21, 2018[5]
June 21, 2019[6]
September 10, 2021[7]

PREAMBLE

The Medical Staff Rules and Regulations are written herein in order to define specific responsibilities and limitations for the members of the Medical Staff when caring for patients in this Hospital. These Rules and Regulations are appended to the Medical Staff Bylaws and serve to extend the language of the Bylaws for the ease of understanding of members of the Medical Staff when interacting with Hospital personnel and policies.

The Rules and Regulations shall be revised as necessary and reviewed at least every two [2] years.(5)

1. **Clinical Inactivity:** If at the time of consideration for reappointment it is determined by the Medical Staff Services Department that the practitioner has had minimal or no clinical activity in the preceding twelve (12) months, the practitioner may be contacted by the Medical Staff Services Department regarding renewal of membership or request for resignation. The practitioner's wishes will be considered in the reappointment process.

2. **Election of Department Chairpersons:** By the end of September in odd-numbered years, a list of physicians for each Department will be compiled by the Medical Staff Services Department using the objective qualifications listed in Section 7.7.1 of the Bylaws. Each physician on the list will be contacted by the Medical Staff Services Department to ascertain interest in serving as Department Chairperson. The response will be notated next to each physician's name. The entire list will be forwarded to the Department for use as a ballot at the Department voting meeting. It is assumed that the voting members will take into consideration the following subjective characteristics when voting for a candidate:

    - reputation for fairness and objectivity
    - willingness and ability to discharge the functions of the office
    - organizational skills
    - communication skills, written and oral

    The elections will proceed as delineated in Section 7.7.2 of the Bylaws.

3. **General Provisions:**

    a) **Alternate Coverage:** Each attending physician must assure timely, adequate professional care for his/her patients in the Hospital by being available or designating a qualified alternate physician with whom prior arrangements have been made and who has requisite clinical privileges at this Hospital to care for the patient.(5)

    In the absence of such designation, the appropriate division chief or department chair has the authority and responsibility to call any member of the Medical Staff with requisite clinical privileges. Failure of an attending physician to meet these requirements may result in a recommendation for action as deemed appropriate by the Medical Executive Committee.(5)

    b) **On-Call Roster:** The monthly on-call roster will be established by each Department Chairperson(5) to assure coverage when possible according to available resources subject to approval of the Medical Executive Committee.

    The Department Chair may delegate this authority to the division chiefs within the department. (5) Upon emergent lapse of coverage the appropriate Division Chief and/or Department Chairperson will notify the Medical Staff President and Chief Medical Officer. Subsequently the appropriate Division Chief and/or(5) Department Chairperson will report this lapse at the next MEC meeting.

        1) The Department/Division must notify the physicians of their on-call status.

        2) The on-call physician must be accessible by phone/beeper or other appropriate venue and is responsible for providing this information to the Medical Staff Services Department. The Medical Staff Services Department will maintain the list and notify the Emergency Department of the call schedule(s) and contact information. The home phone and cell phone(5) numbers must be made available to the Emergency Department.

        3) The on-call physician must be available to verbally(5) respond to an emergency call(5) within thirty (30) minutes. If the on-call physician cannot respond verbally(5), it is his/her responsibility to find another physician who will respond in his/her place or

recommend alternative care resources. In any event, should the ED physician determine that the patient's interests need immediate attention, the ED physician may take any action to address the patient's needs.[1]

4) The on-call physician may sign out to another physician provided that:

   (a) the substituting physician is on the Medical Staff of UH St. John Medical Center with similar privileges;

   (b) the physician signing out must notify the Medical Staff Services Department or Emergency Department the name of the substituting physician prior to the onset of call; and

   (c) the substituting physician must know he/she is taking call and agrees to adhere to normal call responsibilities.

5) If the on-call physician(s) does not respond within 30 minutes, it is at the discretion of the ED attending to determine what is in the patient's best interest. [5]

   (a) The lack of response will be reported to[5] the appropriate Division Chief and/or Department Chairperson within a reasonable timeframe. [5]

   (b) If there is a pattern of non-compliance regarding responding to the ED, the physician will be referred to the appropriate division chief and/or department chair and the Chief Medical Officer. [5]

6) Upon arrival, the patient will be evaluated and stabilized by the ED physician.

   (a) If the ED physician determines the patient has a life or limb-threatening trauma or illness, the on-call specialist[5] physician will be assigned to treat the patient. The private specialist[5] physician, if known, will be notified thereafter of the patient's presence.

   (b) If it is not, in the ED physician's judgment, a life or limb-threatening trauma or illness[5]:

      i. <u>NO ATTENDING PHYSICIAN:</u> When a patient presents to the Hospital Emergency Department and does not have a primary care physician, or the Emergency Department cannot otherwise reasonably determine within a reasonable amount of time of patient's arrival whether such primary care physician exists or is available to respond, the Emergency Department shall promptly refer to the Emergency Department on-call roster and immediately contact the designated physician on-call. Determination of whether a patient has a primary care physician shall be made as soon as possible, but in no way shall this delay or interfere with the Emergency Department's efforts to screen and stabilize the patient. [5]

      ii. <u>ATTENDING PHYSICIAN AVAILABLE:</u> If a patient presents to the Emergency Department and notifies them that he/she has a primary care physician, that primary care physician must be called to assist in managing the patient's care. The Emergency Department's efforts to screen and stabilize the patient shall not, however, be delayed or interrupted to wait for the primary care physician to respond to the Emergency Department or the Hospital. Reasonable efforts must be used to contact the primary care physician to assist in: (1) selecting patient's surgeon, orthopedist, cardiologist and/or other consultant. Notwithstanding the foregoing, the patient (and, if applicable, his/her legal guardian) has the right to select his/her own consultant. (2) Reasonable attempts must be also be made to contact the primary care physician to inform him/her and obtain his/her agreement with respect to any decision to transfer

the patient. The primary care physician is responsible for being available (or, if such primary care physician is a member of a group practice, for making alternate coverage arrangements in compliance with these Rules and Regulations) and, if appropriate, presenting to the Emergency Department to respond, examine and treat patients with emergency medical conditions who have identified the primary care physician as the patient's primary care physician or physician of record. (5)

7) The on-call physician must physically attend the patient in the hospital when requested to do so by the ED attending.(5)

8) Patients may be transferred without examination by the on-call physician if he and the ED attending(5) agree that it is in the patient's best interest to do so prior to the on-call physician's assessment.

9) No patient may be transferred or discharged from the Emergency Department except by a physician who has examined the patient in the Emergency Department.

10) Unless the patient has a specific request(5), the on-call physician will cover in-house consultations if requested to do so.(1) It is expected the hospitalist services will utilize the Emergency Department on-call physicians for consultations. (5)

11) If the patient is assigned to the on-call physician for outpatient follow-up, the physician must be willing to see the patient within 72 hours.(5) The on-call physician must be willing to see the patient at least once for appropriate evaluation and treatment disposition regardless of compensation.(5)

12) Failure to comply with the foregoing rules will be referred to the department chairperson and Chief Medical Officer(5) for consideration with their(5) recommendation forwarded to the MEC.

13) Any practitioner over the age of sixty (60) will have the option not to take call.

c) **Emergency Medical Screening Examination – Qualified Medical Personnel:** A medical screening examination of an individual conducted pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA") and its accompanying regulations, whether conducted in the Emergency Department or otherwise (including the labor and delivery area), may only be performed by a licensed physician (including a resident) or by one of the following categories of non-physician practitioners operating under a valid agreement with a physician member of the Hospital's Medical Staff: Certified nurse practitioners; certified nurse midwives (obstetrics only); physician assistants.(7)

For non-resident physicians and non-physician practitioners listed above, the granting of an applicant or re-applicant privileges to perform emergency medical screening examinations she be further dependent on the processes and approval set forth in the Medical Staff Bylaws.(7)

d) **Drugs:** All drugs and medications administered to patients shall be approved by the Pharmacy, Nutrition(5) and Therapeutics Committee which will take into consideration drugs listed in the latest edition of United States Pharmacopoeia, National Formulary, or A.M.A. Drug Evaluations. Drugs stocked in the pharmacy are to be regulated by the Pharmacy, Nutrition and Therapeutics Committee with the approval of the MEC. Exceptions to the preceding are drugs for clinical investigations which shall be approved by the UH Institutional Review Committee and used in full accordance with Federal Drug Administration regulations.

e) **Informed Consent:** Notwithstanding the obtaining of a patient's general consent for care, when a surgical or other invasive or therapeutic procedure is contemplated, the physician must engage the patient in a thorough discussion of the risks, benefits, and alternatives to the procedure prior to performance of such procedure. This discussion shall be documented and signed on the appropriate consent form prior to the procedure unless there are extenuating

circumstances.[5]

f) **Consultations:** The practitioner requesting consultation must place an order so requesting and notify the consultant. The requesting practitioner must specify the reason for the consultation and the timeframe in which to see the patient: routine (within 24 hours), urgent (within 12 hours), or stat (provide verbal advice within one hour). For urgent or stat consults, it is recommended that the requesting practitioner telephone the consultant. It is expected the hospitalist services will utilize the Emergency Department on-call physicians for consultations if the patient does not have a specific request.[5]

g) **Autopsies:** An autopsy may be performed only with written consent obtained in accordance with state law and in accordance with laboratory, nursing, and administrative policies. All autopsies shall be performed at University Hospitals Cleveland Medical Center unless requested otherwise by the individual authorized to request an autopsy per Hospital policy. In cases where foul play or forensic issues are involved, the coroner should be consulted to determine whether or not an autopsy is desired. The Medical Staff will attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. The Medical Staff, specifically the attending practitioner, will be notified when an autopsy is being performed by the Quality Department.[5] Final diagnoses shall be recorded in the medical record upon completion of the autopsy.[5]

h) **Medical Record Safeguard:** Medical records are the property of the Hospital and are not to be removed from the Hospital unless ordered via a subpoena or court order. Release of confidential medical information will be in conformance with applicable Hospital confidentiality/release of information policies. Electronic records are not to be downloaded onto any unsecure media or transmitted electronically without appropriate authorization.[5]

i) **Medical Record Access:** Previous medical records of patients, in accordance with hospital retention policy,[5] will be available for use of the attending and consulting practitioners regardless of the practitioner of record on previous admissions. Other Hospital personnel are allowed access to a patient's medical record for purposes deemed necessary by Hospital Administration.

j) **Correction/Alterations of Electronic Medical Record:** In a circumstance whereby any portion of a medical record must be altered or corrected due to an errant or incomplete entry, the following rules apply:[5]

1. Any entry into the medical record must be electronically signed.[5]

2. Any alteration may be made only by the person who electronically signed the original entry.[5]

3. The original entry may be edited or changed as long as a discoverable electronic audit trail is maintained along with the record.[5]

4. An addendum may be added to the original entry with updates or changes to the record, with a notification that the record has been amended, date, time and author clearly marked.[5]

k) **Correction/Alterations of the Medical Record Remaining on Paper:**[5] In a circumstance whereby any portion of a medical record must be altered or corrected due to an errant or incomplete entry, the following rules apply:

1. The alteration may be made only by the person who made the original (errant) entry.

2. The error should be crossed out with a single line (not erased or obscured) and initialed and dated by the author.

3. A marginal note should be entered into the record explaining the reason for the

alteration of the record and/or a reference to an addendum may be documented.

4. A corrected entry or addendum should be made in chronological order.

5. If the patient requests the alteration, the record may be modified in the prescribed manner and noted that it was altered at the request of the patient, or the patient may initial and date the altered notation or add a personal signed and dated addendum sheet to the record.

4. **Department/Division Rules and Regulations:** Each clinical department/division shall establish written rules and regulations for the efficient functioning of the department/division and maintenance and improvement of high professional standards. The rules and regulations shall be reviewed and/or[5] updated every three (3) years[5] and approved by the MEC and the Board of Directors.

5. **Psychiatric Services/Substance Abuse Services:** Members of the Medical Staff shall adhere to Administrative and Nursing Policies of the Hospital pertaining to the use of restraints and seclusion. The following key points are emphasized:

(a) Restraints/seclusion may be initiated by the R.N.

(b) A time-limited order from a physician is written within the following timeframes[5] after the initial use of restraints or seclusion.

1. One (1) hour or less for patients less than nine (9) years of age,[5]

2. Two (2) hours for patients from nine (9) to seventeen (17) years, and[5]

3. Four (4) hours for patients eighteen (18) years of age and older.[5]

(c) The patient is attended to at least every fifteen (15) minutes if not under continuous observation to assess comfort, need for toileting, and level of orientation.

(d) Appropriate consultations are obtained.

(e) Appropriate documentation of the use of restraints or seclusion and observation of the patient is written in the medical record.

6. **Admissions**

(a) Admission of patients to the Hospital are restricted to members of the Medical Staff with admitting privileges.

(b) Practitioners may only admit patients requiring care in the specialty for which the practitioner has been granted clinical privileges.

(c) Official Hospital patient registration process[3] is to be followed by all practitioners in order to designate the appropriate type of patient encounter (i.e., elective or emergency admission, observation status, short stay).

The Emergency Department attending will speak with the admitting physician of any patient admitted from the Emergency Department if requested to do so.[4]

(d) A provisional diagnosis is required on all patients prior to registration, except in an emergency. In an emergency a statement giving the reason for the care or a provisional diagnosis is to be recorded as soon as possible thereafter.

(e) Practitioners shall be prepared to justify the medical necessity of patient admissions to appropriate Medical Staff committees. This medical necessity should be clearly reflected in the history and physical exam.

(f) Any patient who presents with a known or life-threatening psychiatric illness, such as suicide or aggressive schizophrenia, etc., who may harm him/herself or others, will be medically evaluated.[5]

1) If an associated medical condition requires admission, he/she will be admitted to the ICU/appropriate floor with adequate supervision.[5]

2) Once medically cleared, the patient will be transferred to the appropriate facility or be seen by psychiatry, if available.[5]

7. **Transfer:** Transfer of physician responsibility within this Hospital or to another facility is documented on a physician order sheet.

8. **Discharges:** Patients are to be discharged only per a written or verbal order by a member of the Medical Staff or authorized representative. The member must complete the medical record as soon as possible following discharge, state the final diagnosis(ses) conforming with nomenclature in use in the Hospital and sign all entries in the record as required. Should a patient leave the Hospital against the advice of the attending practitioner, the patient must sign an appropriate release form.

9. **Deaths:** In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or authorized[5] designee, and that individual shall make an entry in the medical record noting the date, time, and facts relating to death. Appropriate Hospital policies shall be followed regarding release of bodies.

10. **Contracted Services:** In accordance with accreditation requirements, the Medical Staff shall provide advice to hospital leadership about the sources of clinical services to be provided through contractual agreement that have a direct impact on patient care. These services include, but are not limited to, ambulance services, anesthesia services, dialysis services, emergency medicine services, environmental and nutrition services, hospitalist services, intensivist services, pathology services, providers compensated to provide Emergency Department on-call coverage; radiology services; vendors providing clinical equipment; and vendors supplying or repurposing surgical instruments.[5]

11. **Medical Record**

a) **Medication Reconciliation:** Medication reconciliation is an interdisciplinary process between physicians, nursing and pharmacy to create and evaluate an accurate and complete listing of patient prescribed and over the counter medications, and herbal and supplement products. Medication reconciliation is designed to decrease medication adverse events across the continuum of care by review on admission, transfer or discharge to another setting, service, practitioner or level of care within or outside the organization. Admission medication reconciliation must be reviewed by the attending physician within 24 hours.[5]

b) **Orders:** All orders must be timed, dated and signed by the ordering practitioner or another practitioner who is responsible for the care of the patient, even if the order did not originate with him/her. Restraint orders are to be authenticated within twenty-four (24) hours. Verbal orders may be taken and documented only by those individuals specifically designated in Hospital and/or Medical Staff policies and must be authenticated within twenty-four (24) hours. [2]

c) **Admission Note:** An admission note is required as soon as possible after admission but within twenty-four (24) hours after admission and is to be timed, dated and signed.

d) **History and Physical:** The History and Physical must be performed and placed in the medical record within twenty-four (24) hours of the patient's admission to the Hospital and is to be timed, dated and signed.

e) **Interval Note:** When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in lieu of the history and physical examination, provided it is recorded within twenty-four (24) hours of admission and is to be timed, dated and signed.

f) **Progress Notes:** Progress notes are to be completed as often as the patient's condition warrants, but at least daily, and are to be timed, dated and signed.

g) **Operative/Procedure Notes:** Operative reports must be dictated within twenty-four (24) hours. Indications for surgery, preoperative, and postoperative diagnoses should be documented. However, a note must be written immediately after surgery documenting all pertinent information in accordance with regulatory guidelines/standards, ie. Preoperative / postoperative diagnosis, complications, blood loss, procedure performed, etc., and are to be timed, dated and signed.

h) **Consultations:** Consultations are to be timed, dated and signed, and should reflect evidence review of the patient's medical record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations.

i) **Discharge Summary/Clinical Resume:** A discharge summary/ clinical resume is required for all hospitalized patients except for patients hospitalized for forty-eight (48) hours or less, normal newborns, and uncomplicated obstetrical delivery records. A concise final progress note may be substituted for a discharge summary in the above exceptions if the attending practitioner desires and is to be timed, dated and signed.

j) **Abbreviations:** Symbols and abbreviations may be used in accordance with Hospital policy if they are included in the abbreviation list approved by the Medical Staff.

12. **Medical Record Completion:** The attending practitioner is responsible for the completion of each medical record at the time of patient discharge, including progress notes and final diagnosis. A medical record that is incomplete at thirty (30) days after discharge shall be deemed "delinquent." (5)

13. **Incomplete and Delinquent Medical Records:** Unless completed by the attending physician in all respects, medical records are considered to be incomplete at the time of the patient's discharge. If the records remain incomplete thirty (30) days post discharge,(5) they are then considered to be delinquent. Practitioners with incomplete records thirty (30) days post discharge will be notified of suspension of privileges according to the following procedure:

The practitioner will receive a letter each week(5) describing each incomplete medical record and its status. (5)

When a record has been incomplete for twenty-two (22) days, the practitioner will be notified via certified mail of impending delinquency and automatic suspension if the record is not completed within the next eight (8) days; i.e., thirty (30) days from discharge.(5)

If the practitioner completes all records which are causing impending suspension within the prescribed time period(5) no suspension will be imposed.

If a satisfactory explanation for the incomplete record is tendered to the Chief Medical Officer(5) prior to the date of automatic suspension being imposed, an extension of time may be granted.(5)

If the record causing impending suspension is not completed within the timeframes delineated in UHHS Policy #GM-49 (Medical Records Completion)(6), and no satisfactory explanation has been tendered, the record is then considered to be delinquent and automatic suspension will be imposed until the record is completed.(5) Documentation of the automatic suspension will be placed in the practitioner's file for consideration at the time of reappointment.

A Medical Staff members who has one (1) or more incomplete medical record thirty (30) or more days post discharge shall be suspended from all admitting (elective and emergency)[6] and clinical privileges ("clinical suspension"), pursuant to a notice of suspension issued by the Chief Medical Officer. The clinical suspension shall continue until the Manager of Health Information Services determines that the Medical Staff member has completed all incomplete medical records and the Chief Medical Officer determines that the clinical suspension should end. Such clinical suspension will include suspension of access to all Information Services within the Hospital.[5]

When a practitioner has been on suspension for thirty (30)[6] consecutive days, the Medical Staff Services Department shall send him/her a certified letter revoking his/her privileges. The Medical Staff member must complete his/her medical records and pay a reinstatement fee of $500.00 which doubles with each repeat offense.[5]

14. **Retiring Incomplete Medical Records:** In those instances where a practitioner is no longer a member of the Medical Staff due to death, prolonged illness or other extenuating circumstances, the incomplete records will be sent to the Medical Records Committee for a final decision for filing of those incomplete records in the permanent file. A statement will be added to each incomplete record to designate that the record is incomplete and to state the reason why.

15. **Resident Physicians:** Resident physicians are given patient care responsibilities commensurate with the individual's level of training, experience, and capability. In all matters of an individual patient's care, resident physicians are supervised by the attending physician who maintains the responsibility for the care of the patient. For ancillary medical services (Anesthesia, Emergency Medicine, Pathology and Radiology), the department chair or his/her designee will supervise the resident physicians.[5]

A resident physician may be in training at UH St. John Medical Center as a regular part of a clinical rotation. This type of rotation would be established in agreement with the primary training center. Resident physicians may write patient care orders if they have a training certificate or full and unrestricted license issued by the Ohio State Medical Board. Orders need not be countersigned by the supervising attending physician.[5]

Evidence of the resident's training status, a copy of any agreement documenting the training rotation, a copy of the resident's medical license or training certificate, and a copy of the resident's DEA registration certificate (if registered) must be placed in the Medical Education office. Medical residents may attend all educational meetings of the Medical Staff, but may attend business meetings, service, or committee meetings only with the approval of the Committee Chair and/or Medical Staff President.[5]

All qualified residents will be privileged to:

a) Conduct histories and physical exams and document in the patient's chart;[5]

b) Examine assigned patients as required and document the examination in the chart;[5]

c) Change dressings and catheters as directed by the attending physician;[5]

d) Administer medication to and obtain laboratory samples from patients;[5]

e) Perform designated procedures when under the supervision of an attending physician, or his designee, who is privileged to perform those procedures;[5]

f) Assist in the performance of procedures with an attending physician.[5]

The resident may be granted additional privileges at the specific request of an attending physician with documentation of training and ability. The Department Chair and Medical Staff President must approve these privileges pursuant to these Bylaws and applicable law. In addition, all residents have

emergency privileges as defined in the Medical Staff Bylaws.(5)

16. **Activities of Students of Medicine**: Medical students may serve preceptorships under the auspices Medical Staff members, if they are in good standing in the third and fourth year of their accredited school of allopathic or osteopathic medicine.(5)

a) The students' program at UH St. John Medical Center shall be a continuation of their didactic and clinical medical education. They may attend all educational conferences of the Medical Staff and make rounds with the attending physician. They have access to all the educational resources available through the medical library.(5)

b) They may obtain a medical history; however, the preceptor must countersign it on the chart. They must conduct a physical examination with the preceptor or other designated physician present. This will enhance the teaching process at the precise moment the exam is being done.(5)

c) The medical student cannot, unless in the presence of a licensed physician, carry out any procedure that would fall within the definition of delivering healthcare or medical services to a patient.(5)

d) When a medical student scrubs in or assists in obstetric or operative cases, it will be permissible for the name to appear on the record. This record should indicate, for example – *2nd assist, 3rd assist, etc.*(5)

e) The medical student may start intravenous lines, change dressings, remove sutures, etc., providing he/she has shown proficiency and the preceptor has so notified the nursing staff.(5)

f) The medical student may enter orders on the chart given to him/her by the Medical Staff physician. All such chart entries should be further identified, as for example: *MS-4 (medical student, 4th year).* These orders will not be carried out until they are countersigned by the preceptor.(5)

g) All medical student entries in the medical record (orders, histories and physicals, progress notes, etc), must be countersigned by the preceptor.(5)

h) It is imperative that all the medical student's clinical activities be subject to the above guidelines. Any violation of these guidelines should be reported immediately to the attending physician, or preceptor to whom he/she is assigned.(5)

i) No physician shall directly supervise more than two such students at the same time.(5)

j) Medical students may attend all educational meetings of the Medical Staff, but may attend business meetings, service, or committee meetings only with the approval of the Committee Chair and/or Medical Staff President.(5)

k) Neither UH SJMC nor its Medical Staff, makes any implication herewith of its approval of, or formal participation in, such a program or of the content of or jurisdiction over such preceptorships, other than allowing the activities above described, under the supervision and responsibility of the Medical Staff member initiating such program.(5)