



Bylaws of the Medical Staff

Deaconess Union County Hospital

Morganfield, Kentucky

Adopted 8/25/2026

Table of Contents

Article I – Preamble	6
Section 1 – Name	6
Section 2 – Purpose	6
Article II – Definitions	7
Article III – Medical Staff Membership	8
Section 1 – Qualifications	8
Section 2 – Responsibilities	8
Section 3 – Alternate Designee	10
Section 4 – Ethics	10
Section 5 – Emergencies	10
Section 6 – Leave of Absence	11
Section 7 – Hospitalist Coverage Rotation	11
Article IV – Allied Health Providers	11
Section 1 – Qualifications	12
Section 2 – Responsibilities	12
Article V – Categories of the Medical Staff	14
Section 1 - Active Staff	14
Section 2 - Courtesy Staff	14
Section 3 - Consulting Staff	14
Section 4 – Allied Health Providers	15
Section 5 - Senior Staff	15
Section 6 - Honorary Staff	15
Section 7 – Administrative Staff	15
Section 8 - Contract Physicians	16
Article VI – Appointment and Reappointment	16
Section 1 – Qualifications	16
Section 2 – No Entitlement to Appointment	17
Section 3 – Non Discrimination Policy	17
Section 4 – Rights and Duties of Appointees	17
Section 5 - Application	17
Section 6 - Undertakings	18
Section 7 - Burden of Providing Information	19
Section 8 - Authorization to Obtain Information	19
8.1 Immunity:	19
8.2 Authorization to Obtain Information:	20
8.3 Authorization to Release Information:	20
8.4 Definitions	20
Section 9 - Staff Member File	20
Section 10 - Procedure for Initial Appointment	21
10.1 Submission of Application	21
10.2 Initial Credentials Committee Procedure	21

10.3 Subsequent Credentials Committee Procedure.....	21
10.4 Credentials Committee Report	21
10.5 Subsequent Action on the Application.....	22
Section 11 - Procedure for Reappointment	22
11.1 Application Procedure:	22
11.2 Re-credentialing Process- PI	23
11.3 Factors to be Considered.....	23
11.4 Credentials Committee Procedure.....	23
11.5 Meeting with Affected Individual.....	24
11.6 Procedure Thereafter	24
Section 12 - Denial, Non-renewal, Restriction, Suspension or Termination of Privileges	25
12.1 Grounds for Action	25
12.2 Investigative Procedure	25
12.3 Suspension of Privileges	26
12.4 Procedure Thereafter	26
Article VII – Clinical Privileges	27
Section 1 -General.....	27
Section 2 – Delineation of Privileges	27
Section 2 - Dental Privileges.....	27
Section 3 - Allied Health Provider Privileges	28
3.1 Podiatrist Privileges	28
3.2 Other AHP Privileges.....	28
Section 4 – Residents and Medical Students.....	28
Section 5 – Notification of Final Board Action.....	28
Section 6 – Temporary Privileges	29
Section 7 – Termination of Temporary Clinical Privileges	29
Section 8 – Locum Tenens	29
Section 9 - Emergency Privileges	30
Section 10 –Disaster Privileges	30
Section 11 – Request of Increase of Clinical Privileges	31
11.1 Application for Increased Clinical Privileges:	31
11.2 Factors to be Considered:.....	31
Article VIII – Corrective Action.....	32
Section 1 – Grounds for Action	32
Section 2 – Investigative Procedure	32
Section 3 – Procedure Thereafter	33
Section 4 – Suspension of Privileges.....	34
Section 5 – Ground for Suspension.....	34
Section 6 – Credentials Committee Procedure	34
Section 7 – Care of Suspended Individual’s Patients	34
Section 8 – Action by State Licensing Agency	34
Section 9 – Failure to be Adequately Insured.....	35

Section 10 – Failure to Attend Meetings or Satisfy Continuing Education Requirements	35
Section 11 – Penalty for Violation of Bylaws and Rules and Regulations	35
Article IX – Hearing and Appeal Procedures	35
Section 1 – Purpose	35
Section 2 – Actions That Entitle a Practitioner to a Hearing	36
2.1 Grounds for Hearing	36
2.2 Unappealable Actions	36
Section 3 – Notice of Adverse Action	36
Section 4 – Request for Hearing.....	36
Section 5 – Hearing Panel	36
5.1 Hearing Officer	37
5.2 Record of Hearing.....	37
5.3 Admissibility of Evidence	37
5.4 Official Notice	37
5.5 Attendance by Panel Members.....	37
Section 6. Hearing Rights	38
6.1 Notice of Hearing and Statement of Reasons.....	38
6.2 Representation.....	38
6.3 Rights of Both Sides.....	38
6.4 List of Witnesses	38
6.5 Failure to Appear	38
6.6 Postponements and Extensions	39
6.7 Adjournment and Conclusion	39
Section 7. Burden of Proof	39
Section 8. Conduct of the Hearing.....	39
Section 9. Hearing Panel Recommendation.....	39
9.1 Deliberations and Recommendations of the Hearing Panel.....	39
9.2 Disposition of Hearing Panel Report	40
Section 10. Appellate Review	40
10.1 Time For Appeal.....	40
10.2 Grounds For Appeal.....	40
10.3 Time, Place and Notice	40
10.4 Nature of Appellate Review	40
10.5 Final Decision of The Board.....	41
10.6 Further Review	41
10.7 Right To One Appeal Only.....	41
Article X – Structure of the Medical Staff.....	41
Section 1 – Authority.....	41
Section 2 – Relationship to the Governing Board	42
Section 3 – Committees.....	42
Article XI – Officers.....	42
Section 1- The Chief	42

Section 2 – Vice Chief of Staff.....	43
Section 3 – The Secretary-Treasurer	44
Section 4 - Election of Officers	44
Section 5 – Vacancies in Office	44
Article XII – Clinical Departments.....	44
Article XIII –Committees of the Medical Staff	45
Section 1 – Purpose	45
Section 2 – Committee Appointments	45
2.1 Chairmen.....	45
2.2 Members.....	45
Section 3 – Medical Executive Committee	45
3.1 Composition	45
3.2 Rules of Orders	45
3.3 Duties	45
3.4 Combined Meetings	46
3.5 Annual Medical Staff Meeting.....	46
3.6 Agenda	46
Section 4 - Provisions Common to Meetings of the Medical Staff	47
4.1 Notice of Meetings.....	47
4.2 Attendance Requirements	47
4.3 Quorum	48
4.4 Voting	48
Section 5 – Credentials Committee	48
5.1 Composition	48
5.2 Duties	48
5.3 Meetings, Reports and Recommendations	48
5.4 Special Committee Meetings	48
5.5 Minutes.....	49
Section 6 – Bylaws Committee	49
6.1 Composition	49
6.2 Duties	49
6.3 Meeting, Reports and Recommendations	49
Section 7 – Emergency & Trauma Committee	49
7.1 Composition	49
7.2 Duties	49
7.3 Meeting, Reports and Recommendations	50
Section 8 – Multi Departmental Committee	50
8.1 Composition	50
8.2 Duties	50
8.3 Meeting, Reports and Recommendations	50
Section 9 – Pharmacy & Therapeutics Committee.....	50
9.1 Composition	50

9.2 Duties	51
9.3 Meeting, Reports and Recommendations	51
Section 10 – Surgical Case Review Committee	51
10.1 Composition	51
10.2 Duties	51
10.3 Duties of Surgical Case Review Committee in Reference to Transfusions	51
10.4 Meeting, Reports and Recommendations	52
Section 11 – Peer Review Committee	52
11.1 Composition	52
11.2 Duties	52
11.3 Meeting, Reports and Recommendations	52
Section 12 – Standing Medical Staff Committees	52
Section 13 – Ad Hoc Committees	52
Article XV – Rules and Regulations	53
Article XVI – Amendments	53
Article XVII – Adoptions	53
Appendix B	54

Deaconess Union County Hospital Bylaws of the Medical Staff

The following Bylaws of the Medical Staff of Deaconess Union County, Inc., d.b.a. Deaconess Union County Hospital, will comprise Part II of the Corporate Bylaws of the Deaconess Union County Hospital in Morganfield, Kentucky.

Article I – Preamble

Recognizing that the Medical Staff is responsible for the quality of medical care, education, and research carried out in this Hospital, and that it must assume these responsibilities, subject to the ultimate authority of the Board. Recognizing that the best interests of the patients entrusted to its care are met by cooperative effort, the physicians, oral surgeons, and dentists practicing their profession at Deaconess Union County Hospital, are hereby organized in conformity with these Bylaws, Rules and Regulations here stated.

Section 1 – Name

The name of this organization shall be the Medical Staff of the Deaconess Union County, Inc., d.b.a. Deaconess Union County Hospital.

Section 2 – Purpose

Part A:

The purpose of this organization shall be:

1. To secure and maintain a high standard of medical efficiency consistent with the dictates of the medical and legal aspects of the practice of medicine.
2. To provide all patients admitted to this Hospital the best possible care.
3. To provide an effective organization for the scrutiny and evaluation of medical practice in the Hospital so as to make unbiased recommendations to the Board for improvement of medical practice in the Hospital.
4. To provide education and to maintain educational standards for the personnel engaged in or dedicated to the care of sick patients in the Hospital, and
5. To provide a means whereby problems of a medical administrative nature may be discussed by the Medical Staff, the Board and Administration.

Part B:

The Medical Staff, as an integral part of the Deaconess Hospital Quality and Safety Program, shall meet its duties, responsibilities and take action to further its purpose of providing the best possible care to their patients and provide effective scrutiny and evaluation of medical practices at Deaconess Union County Hospital. It is the intent of the Medical Staff to avail itself of the provisions of the Patient Safety and Quality Improvement Act codified in 42 USC 2996-21-26.

Then Medical Staff is voluntarily participating in the Act to ensure that any information, oral, written, electronic, or otherwise, that could improve patient safety, healthcare quality or healthcare outcomes is considered as Patient Safety Work Product. It is the intent that Medical Staff peer review process is coordinated with the Methodist Hospital quality and safety process for reporting to Patient Safety Organizations and/or is within the Hospitals Patient Safety Evaluation System.

Any information collected, assembled, maintained or is developed or exists separately that is used in the evaluation and/or analysis to improve patient safety, healthcare quality or healthcare outcomes is considered Patient Safety Work Product.

This Article I Part B shall apply to all information collected, assembled, maintained or is developed or exists separately that is used to meet all actions, duties, and responsibilities conducted in the furtherance of its purpose pursuant to these Bylaws.

Article II – Definitions

The following definitions shall apply to terms used in these Bylaws:

- A. “Hospital” means Deaconess Union County Hospital, INC.
- B. “Governing Board” means the Board of Directors of the Deaconess Union County, Inc., who has the overall responsibility for the conduct of the Hospital including the Medical Staff.
- C. “Chief Administrative Officer” (“CAO”) means the individual appointed by the governing board of the Hospital to act in its behalf in the overall management of the Hospital.
- D. “Executive Committee” or “MEC” means the Medical Executive Committee unless specifically written “Executive Committee of the Board”.
- E. “Medical Staff” means all physicians and dentists who are given privileges to treat patients in the Hospital.
- F. “Physicians” shall be interpreted to include both doctors of medicine and doctors of osteopathy.
- G. “Practitioner” means an appropriately licensed medical and osteopathic physician, dentist or allied health provider.
- H. “Advanced Practice Registered Nurses (APRNs)” means certified nurse midwives, certified nurse practitioners, clinical nurse specialists and certified nurse anesthetists as defined by KRS § 314.011.
- I. “Medical Staff Year” means the period from January 1st through December 31st.
- J. Words used in these Bylaws shall be read as masculine, feminine or neuter gender, and as singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.
- K. “Physicians’ Hospital mailbox” should be interpreted to mean that space in the Medical Records Department dedicated to the distribution of reports and communications from the Hospital to the physician.
- L. “Hospital bulletin board” is defined as the bulletin board located in the doctors’ lounge for the purpose of transmitting general Medical Staff information.
- M. “Emergency” is defined as a medical event that has the potential for causing a disabling and/or dismembering injury to the body or mind, or death.

Article III – Medical Staff Membership

Section 1 – Qualifications

- A. Physicians or dentists may qualify for membership of the medical staff and for privileges if adequate documentation of the following are provided:
 - 1. Licensure in Kentucky as a physician or dentist.
 - 2. Training, experience and demonstrated competence.
 - 3. Ability to maintain his or her practice within the service area of the Hospital.
 - 4. Adherence to the code of ethics of the American Medical Association, American College of Surgeons, the American Dental Association or the American Osteopathic Association, whichever is applicable (see Appendix B), and a good reputation.
 - 5. Ability to work with others in a cooperative, professional manner in the provision of patient care and in the orderly functioning of the Hospital.
 - 6. Ability to make efficient use of Hospital facilities so as not to jeopardize the financial stability of the Hospital.
 - 7. Good physical, mental and emotional health.
 - 8. Possession of current, valid professional liability insurance coverage in such form and amounts satisfactory to the Hospital.
- B. The documentation provided by the physician or dentist must be sufficient to assure the medical staff and Hospital governing board that any patient treated by the physician or dentist in the Hospital will be given an appropriate level of medical care.
- C. No physician or dentist shall be entitled to membership on the staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice medicine or dentistry in this or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past or presently has any such privileges at these or other hospitals, or that he or she is employed by the Hospital.
- D. No decisions on staff membership or privileges will be influenced by an applicant's race, religion, sex, sexual orientation, age, national origin, or citizenship or on the basis of any handicap which does not affect a practitioner's ability to provide care to patients with or without reasonable accommodations.
- E. Certification by the Education Commission for Foreign Medical Graduates is required for graduates outside of the United States and Canada.

Section 2 – Responsibilities

- A. Application for and/or acceptance of membership of the medical staff shall constitute the agreement of the applicant or staff member to:
 - 1. Abide by the Principles of Medical Ethics of the American Medical Association, American Osteopathic Association, American College of Surgeons or the American Dental Association, whichever is applicable, as well as the Deaconess Henderson Hospital Code of Conduct when practicing in the Hospital. These professional ethical codes are made a part of these Bylaws (see Appendix "B");
 - 2. Abide by all of the terms and provisions of these Bylaws as they now exist and as they shall be amended; by all of the rules and regulations of the medical staff as may now exist and

as they shall be amended; by all of the policies and procedures of the Hospital as they now exist and as they shall be amended.

3. Authorize the members of the medical staff as agents of the Hospital governing board to investigate and to gather any relevant information which would otherwise be confidential or privileged concerning the applicant or staff member with regard to his or her qualifications to exercise privileges in the Hospital;
 4. Authorize all people and organizations to release such information to the Hospital governing board, its agents and/or employees;
 5. Release and hold harmless all persons, organizations (including the Hospital), the governing board of the Hospital, personnel of peer review committees, their agents, employees and all others who participate in good faith in providing, receiving, evaluating, or taking any action on such information regarding the applicant, staff member, or allied health care provider;
 6. Certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at the Hospital, and conflicts of interest and obligation to document compliance on request; and
 7. Conduct himself or herself at all times at the Hospital without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion.
 8. Notify promptly the Hospital in writing if the applicant or staff member has been excluded from participation in the Medicare and Medicaid program, convicted of a felony, or has had his or her professional license, CSR or DEA certificates or clinical privileges at any facility terminated, restricted, suspended or modified.
- B. It is the duty of the medical staff as the agent of the Hospital governing board to examine the credentials of all persons requesting privileges as members of the medical staff or as allied health care providers and to recommend to the governing boards specific delineation of privileges.
- C. It is the duty of each member of the medical staff to maintain and demonstrate continuously the appropriate level of competence and professional conduct which would justify the continuance of staff membership and specific privileges granted. The failure of any medical staff member to demonstrate the requisite level of competence and professional conduct in providing patient care will necessitate corrective action and may result in the termination of medical staff membership and any Hospital privileges which the staff member had been granted.
- D. All medical staff members will refrain from delegating the responsibility for diagnosis and/or care of hospitalized patients to a medical or dental practitioner who is not qualified to undertake that responsibility or to other paramedical personnel who are not adequately supervised.
- E. All medical staff members will seek consultation when appropriate, and particularly in cases where the diagnosis is obscure, the best therapeutic measures are in doubt, or problems arise that are beyond their expertise.
- F. All active, senior and courtesy staff members and all other independent contractor practitioners are responsible for their own acts and omissions, and will carry in full force and effect, at their expense, continuous professional liability (malpractice) insurance or such kind, in such amount and underwritten by such insurers as required by Kentucky law or as required by the governing board after consultation with the MEC, whichever requirement is more

stringent, and will promptly notify the Hospital in writing of any change in or termination of such insurance coverage while a member of the medical staff.

- G. Each admitting staff member is responsible for providing continuous care and supervision of his or her patients, including adequate and appropriate coverage for patients when he or she is not available.
- H. All medical staff members will accept committee assignments, consultation and proctoring assignments, and participate in the educational programs of the staff and Hospital at which they have privileges.
- I. All medical staff members will acknowledge the provisions of Section 413 of the Health Care Quality Improvement Act of 1986 which permits the recovery of reasonable attorney's fees and costs in the defense of any suit brought by a practitioner concerning clinical privileges when the defendants have acted in compliance with the standards set forth in the Act.
- J. All medical staff members agree to submit, on request, to an appropriate examination or testing of his or her physical, mental and emotional health.

Section 3 – Alternate Designee

- A. Each member of the Medical Staff shall name another member of the Medical Staff who may be called to attend to his/her patients in case of an emergency or in the event of his/her absence. An Alternate Designee form will be signed and kept on file in the Medical Staff Office.
- B. If a physician agrees to cover another physician, either as "Alternate Designee" or by agreement, it is the responsibility of the covering physician to provide care for the patient or to locate another physician to care for the patient. In the event, this responsibility is not carried out the physician, who agreed to cover, will be asked to appear before the Executive Committee and explain his/her actions. Contract physicians will be responsible for coverage as per agreement.
- C. The Chief of Staff shall do all in his/her power to call a physician on emergency duty or any physician on the Active Staff if he/she considers it necessary for the welfare of the patient.

Section 4 – Ethics

The principal ethics of the American Medical Association shall govern the professional conduct of the members of the Medical Staff. The Medical Staff shall be expected to conduct themselves in accordance with the requirements of nationally recognized hospital and medical standardizing agencies, and the members of the Medical Staff shall pledge themselves that they will not receive from or pay to another physician, osteopath, or dentist, either directly or indirectly, any part of fees received for professional services. The same principals of ethics shall apply to the dentists in accordance with or with the Code of Ethics of the American Dental Association.

Section 5 – Emergencies

In case of an emergency, the physician attending a patient shall be expected to do all in his power to save the life of the patient including the calling of such consultations that may be available or indicated.

Certification of clinical specialty or limitation of practice shall not excuse any physician as a member of the Active Medical Staff who admits a patient from participating in the emergency duties of the Hospital.

Section 6 – Leave of Absence

Medical Staff members may be granted a leave of absence by the Board for good cause for a specified period not to exceed one year. An absence longer than one year shall be considered a voluntary resignation of Medical Staff appointment and clinical privileges unless the Board approves an exception.

Requests for leaves of absence shall be made to the Chief of Staff and shall state the beginning and ending dates of the requested leave. The Chief of Staff shall transmit the request together with his/her recommendation to the Credentials Committee which shall make a report and a recommendation and transmit it to the Executive Committee. The Executive Committee shall transmit its recommendation to the Board for final approval.

At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the Executive Committee summarizing his/her professional activities during the leave of absence. The individual shall also provide such other information as may be requested by the Hospital at that time. Final approval will be given by the Board.

In acting upon the request for reinstatement, the Board may approve reinstatement to either the same or a different staff category and may recommend limitations or modification of the clinical privileges to be extended to the individual upon reinstatement.

Section 7 – Hospitalist Coverage Rotation

- A. The Medical Staff shall be responsible for the professional care of all patients entering the Hospital without a professional attendant and shall provide, at all times, rotation medical services for all patients who report to the emergency room of the Hospital for care or are a direct admission from a physician office.
- B. The rotation for medical care shall be prepared in the Administrative offices, unless a request is made by physicians in a specialty group to prepare their own schedules. In those cases, the schedule will be prepared by the physicians in that specialty group and presented then to the administrative offices, and upon approval by the, shall be distributed in the usual fashion to the staff physician Hospitalists. Failure of any duties shall be reported to the Medical Staff/Executive Committee for consideration and recommendation.
- C. Active Medical Staff members are not required to provide primary emergency room rotation; however, they may be asked to provide specialty consultation or back-up when required and requested by the Chairman of the Emergency Room and Trauma Committee.

Article IV – Allied Health Providers

An Allied Health Provider (AHP) is a licensed or otherwise authorized healthcare practitioner, other than a physician (MD/DO) or dentist, who is permitted by applicable federal and Kentucky law to provide patient care services within the scope of his or her education, training, experience, certification, licensure, and clinical privileges granted by the Governing Body.

Examples include, but are not limited to:

- Advanced Practice Registered Nurses (APRNs)
- Physician Assistants (PAs)
- Certified Registered Nurse Anesthetists (CRNAs)

- Certified Nurse Midwives (CNMs)
- Certified Registered Nurse First Assistants (CRNFAs)
- Clinical Psychologists
- Podiatrists
- Optometrists
- Other practitioners approved by the Governing Body

Section 1 – Qualifications

- A. Allied health providers to be eligible for appointment and clinical privileges and approved by the Board shall:
 1. Hold a current, unrestricted Kentucky license, registration, or certification, as applicable.
 2. Education, training, experience and demonstrated competence.
 3. Adherence to the ethics of their professions and a good reputation.
 4. Ability to work with others in a cooperative professional manner in the provision of patient care.
 5. Ability to maintain their practice within the service area of the Hospital.
 6. Ability to make efficient use of hospital facilities so as not to jeopardize the financial stability of the Hospital.
 7. Good physical, mental and emotional health.
 8. Demonstrate current competence.
 9. Maintain professional liability insurance meeting Hospital requirements.
 10. Comply with these Bylaws, Medical Staff Rules and Regulations, Hospital policies, and applicable laws.
 11. Maintain collaborative or supervisory agreements when required by state law and applicable.
- B. The documentation provided by the allied health provider must be sufficient to assure the medical staff and governing board that any patient treated by the allied health provider in the Hospital will be given an appropriate level of medical care under the direction of a medical staff member.
- C. No allied health provider shall be entitled to exercise privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice his or her profession in this or another state, or that he or she is a member of any professional organization, or that he or she had in the past or presently has such privileges at this hospital or other hospitals.
- D. No decisions on appointment as an allied health provider with specific privileges will be influenced by an applicant's race, religion, sex, sexual orientation, age, national origin, or citizenship or on the basis of any disability which does not affect a practitioner's ability to provide care to patients with or without reasonable accommodations.

Section 2 – Responsibilities

- A. Allied Health Provider shall:
 1. Abide by the code of ethics which governs his or her professional category and/or organization and the Hospital Code of Conduct.

2. Abide by all of the terms and provisions of these Bylaws as they now exist or as they shall be amended; by all of the rules and regulations of the medical staff as may now exist and as they shall be amended; by all of the policies and procedures of the Hospital as they now exist and as they shall be amended.
 3. Authorize the members of the medical staff as agents of the Hospital governing board to investigate and to gather any relevant information which would otherwise be confidential or privileged concerning the applicant or provider with regard to his or her qualifications to exercise privileges at the Hospital.
 4. Authorize all persons and organizations to release such information to the Hospital governing board, their agents and/or employees. Release and hold harmless persons, organizations (including the Hospital), the governing board of the Hospital, personnel of peer review committees, their agents and employees and all others who participate in good faith in providing, receiving, evaluating, or acting on such information regarding the applicant or provider.
 5. Abide by the credentialing and peer review process of the medical staff, although the providers shall not be members of the medical staff, shall not vote in medical staff elections or deliberations, and are not required to attend medical staff meetings.
 6. Certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at the Hospital, and conflicts of interest and obligation to document compliance on request.
 7. Conduct themselves at all times at the Hospital without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion.
 8. Notify the Hospital promptly in writing if the applicant or provider has been excluded from participation in the Medicare and Medicaid Program, convicted of a felony, or has had his or her professional license, CSR or DEA certificates or clinical privileges at any facility terminated, reduced, restricted, suspended or modified.
- B. It is the duty of each allied health provider to maintain and demonstrate continuously the appropriate level of competence and professional conduct which would justify the continuance of those privileges granted. The failure of any allied health care provider to demonstrate the requisite level of competence and professional conduct in providing patient care will necessitate corrective action and may result in the termination of any privileges which the allied health provider may have been granted.
 - C. Each allied health care provider agrees to provide continuous care and supervision of his or her patients and to seek consultation when appropriate.
 - D. Each allied health provider agrees to accept committee assignments, to accept consultation and proctoring assignments, and to participate in the educational programs of the staff and Hospital.
 - E. Each allied health provider agrees to provide proof of continuous professional liability insurance and promptly notify the Hospital in writing of any change in or termination of such insurance coverage while holding privileges at the Hospital.
 - F. Each allied health provider agrees to submit, on request, to appropriate examination or testing of his or her physical, mental and emotional health.
 - G. Locum Tenens allied health providers initial appointments will be for a maximum of one (1) year and will automatically terminate unless an application for continuation of such privileges is submitted by the applicant at least 120 days prior to their termination. If a timely application

for continuance of such privileges is received, credentialing and privileging will be performed with respect to the application.

Article V – Categories of the Medical Staff

All appointees shall be eligible for clinical privileges as applied for and recommended pursuant to these Bylaws and approved by the Board. All appointments to the Medical Staff shall be made by Board, and shall be to one of the following categories of the staff.

The medical staff shall be divided into Active, Senior, Courtesy, Consulting, Administrative staff, and Allied Health Provider.

In addition to the six categories of members of the medical staff, there is one category of non-member staff - Honorary Staff.

A (6) six-month provisional period is required in the Active, Consulting, Courtesy, and Allied Health Provider categories prior to being eligible for full staff membership.

Section 1 - Active Staff

The Active Staff shall consist of those physicians who attend or are involved in the treatment of at least twenty-five (25) patients per year at the Hospital. Each appointee to the Active Staff shall agree to assume all the functions and responsibilities of appointment to the Active Staff, including, where appropriate, care for unassigned patients, emergency service care, consultation and teaching assignments. Active Staff appointees shall be entitled to vote, hold office, serve on Medical Staff committees, and serve as chairmen of such committees. Active Staff appointees shall be required to attend Medical Staff meetings. Members of the Active Medical Staff shall not be required to be specialists in any particular branch of medicine or surgery. Only physicians who have been granted privileges at this institution may perform a complete history and physical examination.

Section 2 - Courtesy Staff

The Courtesy Staff shall consist of physicians and dentists of demonstrated competence qualified for staff appointment who are not eligible for appointment to the Active Staff because they do not intend during each appointment year to admit, or be involved in the care of more than twenty-five (25) patients per year at the Hospital. Courtesy Staff appointees may have Medical Staff committee responsibilities, may vote, and may hold office. They are encouraged to attend staff meetings.

Section 3 - Consulting Staff

The Consulting Staff shall consist of those physician specialists, and dentists appointed to the Medical Staff for the purpose of increasing and/or enhancing the medical services provided to the patients of the institution. Appointment to the Consulting Staff shall not entitle the appointee to admit, but may only provide consultative service to patients of the institution. Consulting Staff may order treatment for their patients. In case of any problems, the consulting physician will be notified. There shall be no limit to the number of patients in whose care the appointee may be involved. The appointee may not:

- Be responsible for providing emergency room coverage.
- Be required to serve on Medical Staff committees.
- Be required to attend Medical Staff committee meetings.

- Be entitled to vote on Medical Staff matters.
- Hold a Medical Staff office.

To be appointed to the Consulting Staff, the appointee must meet the following criteria:

- A. Have completed a residency training program in his/her medical field approved by the Accreditation Council for Graduate Medical Education of the American Medical Association,
- B. Be a sub-specialist in one of the following fields:
 1. Surgery
 2. Medicine
 3. Pediatrics
 4. OB/GYN
 5. Radiology

Section 4 – Allied Health Providers

Allied Health Providers category shall consist of non MD/OD physicians and dentists. AHP Staff appointees do not have Medical Staff committee responsibilities, may not vote, and may not hold office. They are encouraged to attend staff meetings.

Section 5 - Senior Staff

The Senior Staff shall consist of physicians and dentists who have attained the age of seventy (70), or have served on the medical staff for a total of twenty-five (25) years, or have been promoted for reasons of health. They maintain voting privileges as well as retain privileges to admit and treat patients.

Senior Staff may continue to admit and care for patients shall have the same prerogatives that they had previous to attaining Senior status, including the right to vote and hold office, if applicable. The Senior Staff have no responsibility to rotate on the Emergency Room Call schedule for patients who have no physician and are not required to pay staff dues. They are urged to attend medical staff and their respective department meetings, but such attendance is not compulsory.

Section 6 - Honorary Staff

The Honorary Staff shall consist of Medical Staff appointees who have retired from active Hospital practice or other physicians or dentists who are of outstanding reputation, not necessarily residing in the community. Persons appointed to the Honorary Staff shall not be eligible to admit or attend patients, to vote, to hold office, but may serve on standing committees if appointed by the Chief of Staff, provided he/she agrees to serve in that capacity. Honorary Staff Members may be appointed to special committees but are not required to attend any Medical Staff meetings.

Section 7 – Administrative Staff

The Administrative Staff shall consist of physicians or dentists who are retained solely to provide medical administrative functions within the Hospital and do not perform any active patient care duties.

- Administrative Staff are not eligible to admit patients to the Hospital or otherwise render medical care.
- Administrative Staff may actively participate on Hospital committees and serve as voting members but shall not be eligible to hold elective office positions such as Department Chair or Committee chair positions.

- Administrative Staff are not subject to OPPE for the purpose of credentialing or re-credentialing.

Section 8 - Contract Physicians

The Board shall have the authority to enter into contracts for employment relationships with physicians for the performance of certain services. All physicians functioning pursuant to such contracts or employment relationships, in the performance of clinical medicine, shall attain and maintain staff appointment and clinical privileges, which shall be processed as described in the Medical Staff Bylaws. If a question arises concerning clinical competence or clinical privileges during the term of the contract, that question shall be resolved in the same manner as would pertain to any other appointee to the Medical Staff using the due process procedures of the Medical Staff and Corporate Bylaws. If a modification of privileges or appointment resulting from such action is sufficient to prevent the physician from performing his/her contractual duties, the contract shall automatically terminate except as hereinafter provided.

The Board may enter into Exclusive Personal Service Agreements (e.g. radiology). All physicians functioning pursuant to such Agreements in the performance of clinical medicine shall attain and maintain staff appointment and privileges which shall be processed as described in the Medical Staff Bylaws. Neither clinical privileges nor staff appointment will survive the termination of a contract or employment nor will termination of those privileges pursuant to termination of contract entitle a physician to any hearing and appeals procedure unless there is a specific provision to the contrary in the contract. In the event that only a portion of a physician's clinical privileges are covered by the Contract or employment, only that portion shall be affected by the expiration or termination of the contract or employment.

Specific contractual or employment terms shall, in all cases, be controlling in the event that they conflict with provisions of the Medical Staff Bylaws.

All physicians contractually required to be members of the Active Medical Staff, shall be considered for committee assignment.

Article VI – Appointment and Reappointment

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who meet the qualifications, standards and requirements set forth in these Bylaws and in such policies as are adopted from time to time by the Board.

Section 1 – Qualifications

Practitioners who:

- Are currently licensed to practice in this state.
- Are located within the geographic service area of the Hospital, close enough to provide timely care for their patients.
- Possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital.
- Can document their background, experience, training and demonstrated competence.
- Can adhere to the ethics of their profession.

- Possess a good reputation and character, including the applicant's mental and emotional stability.
- Ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them in the Hospital will receive quality care, and that the Hospital and its Medical Staff will be able to operate in an orderly manner, shall be qualified for appointment to the Medical Staff.

Section 2 – No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that:

- He/she is licensed to practice any profession in this or any other state.
- He/she is a member of any particular professional organization.
- He/she had in the past, or currently has Medical Staff appointment or privileges in this or another Hospital.

Section 3 – Non Discrimination Policy

No individual shall be denied appointment on the basis of sex, race, creed, color or national origin.

Section 4 – Rights and Duties of Appointees

Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board and shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require.

Section 5 - Application

Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by the Board upon recommendation of the Executive Committee. These forms shall be obtained from the Medical Staff Office or the CAO. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

- A. The names and complete addresses of at least two physicians, dentists or other practitioners, as appropriate, who have had recent experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character.
- B. The names and complete addresses of the chiefs or chairmen of each service or department of any and all Hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chairmen or chiefs at the time the applicant worked in the particular department/service). If the number of Hospitals the applicant has worked in is great, or if a number of years has passed since the applicant worked in a particular Hospital, the Executive Committee and the Board may take into consideration the applicant's good faith effort to produce this information.
- C. Information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been resigned, denied, revoked, suspended, reduced, or not renewed at any other Hospital or health care facility.
- D. Information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment and clinical privileges before final decision by a Hospital's or health care facility's governing board.

- E. Information pertaining to the loss of clinical privileges at another institution and whether the applicant's membership in local, state or national professional societies or his/her license to practice any profession in any state, or his/her Drug Enforcement Administration license has been suspended, modified terminated or voluntarily relinquished. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as a copy of his/her Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post graduate training programs completed.
- F. Information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, and the amount and classification of such coverage.
- G. Information concerning applicant's malpractice litigation experience.
- H. Consent to release of information from the applicant's present and past professional liability insurance carriers.
- I. Information on the applicant's physical and mental health.
- J. Information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance.
- K. Information on the citizenship and visa status of the applicant.
- L. The applicant's signature.
- M. Such other information as the Board may require.
- N. Information as to whether applicant has had previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.
- O. Information as to whether applicant has had voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital.

Section 6 - Undertakings

The following undertakings shall be applicable to every Medical Staff appointee and applicant for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

- A. An obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the individual has responsibility.
- B. An agreement to abide by all Bylaws and policies of the Hospital, including all Bylaws, Rules and Regulations of the Medical Staff as shall be in force from time to time during the time he/she is appointed to the Medical Staff.
- C. An agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him/her by the Board and the Medical Staff.
- D. An agreement to provide the Hospital, upon request or without request, current information regarding all questions on the application form at any time, new or updated information that is pertinent to any question on the application form.
- E. A statement that the applicant has received and had an opportunity to read a copy of the Bylaws of the Hospital and Bylaws Rules and Regulations of the Medical Staff as are in force at the time of his/her application, and that he/she has agreed to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted appointment to the Medical Staff or clinical privileges.
- F. A statement of his/her willingness to appear for personal interviews in regard to his/her application.
- G. A statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the

application, resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in summary dismissal from the Medical Staff.

A statement that the applicant will:

- A. Refrain from fee splitting or other inducements relating to patient referral.
- B. Refrain from delegating responsibility for diagnoses or care of Hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised.
- C. Refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services.
- D. Seek consultation whenever necessary.
- E. Abide by generally recognized ethical principles applicable to his/her profession.
- F. Provide continuous care for his/her patients in the Hospital.
- G. Each applicant for Medical Staff appointment and reappointment shall specifically agree to these undertakings as part of his/her application.

Section 7 - Burden of Providing Information

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications. He/she shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. Until the applicant has provided all information requested by the Hospital, the application will be deemed incomplete and will not be processed.

Section 8 - Authorization to Obtain Information

The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges in the Hospital. By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he/she is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

8.1 - Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, and extends absolute immunity to the Hospital, its authorized representatives, and any third parties as defined in subsection 8.2 below, with respect to any acts, communications, or documents, recommendations, or disclosures involving the individual, concerning the following:

- A. Applications for appointment or clinical privileges, including temporary privileges.
- B. Evaluations concerning reappointment or changes in clinical privileges.
- C. Proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction.
- D. Summary suspension.
- E. Hearings and appellate reviews.
- F. Medical care evaluations.

- G. Utilization review.
 - H. Other activities relating to the quality of patient care or professional conduct.
 - I. Matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior.
 - J. Any other matter that might directly or indirectly have an effect on the individual's competence, on patient care, or on the orderly operation of this or any other Hospital or health care facility.
- The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the Hospital and its authorized representatives, and to any third parties.

8.2 - Authorization to Obtain Information:

The individual specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

8.3 - Authorization to Release Information:

Similarly, the individual specifically authorizes the Hospital and its authorized representatives to release such information to other Hospitals, health care facilities, and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

8.4 - Definitions

- A. As used in this section, the term "Hospital and its authorized representatives" means the Hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon the individual's application or conduct in the Hospital; the members of its Board and their appointed representatives; the CAO or his/her designees; consultants to the Hospital; the Hospital's attorney and his/her partners, associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon his/her application or conduct in the Hospital.
- B. As used in this section the term "third parties" means all individuals, including appointees to the Hospital's Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether Hospitals, health care or not, from who information has been requested by the Hospital or its authorized representatives.

Section 9 - Staff Member File

A separate record shall be maintained on each applicant and each staff member and shall remain on file in the Medical Staff Office.

Section 10 - Procedure for Initial Appointment

10.1 - Submission of Application

The application for Medical Staff appointment shall be submitted by the applicant to the Credentials Committee. After receiving references and other information or materials deemed pertinent, the Credentials Committee shall determine the application to be complete. It is the responsibility of the applicant to submit a complete application, including adequate responses from references. An incomplete application will not be processed.

10.2 - Initial Credentials Committee Procedure

Upon receipt of the complete application for appointment, the Credentials Committee shall Post the name of the applicant on the bulletin board so that each Medical Staff appointee may have an opportunity to submit to the committee, in writing, information bearing on the applicant's qualifications for staff appointment. In addition, any current Medical Staff appointee shall have the right to appear in person before the Credentials Committee to discuss, in private and in confidence, any concerns he/she may have about the applicant.

10.3 - Subsequent Credentials Committee Procedure

- A. The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior, and ethical standing of the applicant, and shall determine, through information contained in references given by the applicant, and from other sources available to the committee, whether the applicant has established and meets all of the necessary qualifications for the staff category and clinical privileges requested by him/her.
- B. As a part of this process, the Credentials Committee may require a physical and mental examination of the applicant by a physician or physicians satisfactory to the Committee and shall require that the results be made available for the Committee's consideration.
- C. If the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional clinical privileges.
- D. As part of the process in making its recommendation, the Credentials Committee shall have the right to require the applicant to meet with the Committee to discuss any aspect of his/her application, his/her qualifications, and his/her clinical privileges.

10.4 - Credentials Committee Report

- A. Not later than 120 days from its receipt of the completed application, provided the necessary information can be obtained, the Credentials Committee shall make a written report and recommendation, with respect to the applicant, to the Medical Staff/Executive Committee.
- B. If the recommendation of the Credentials Committee is delayed longer than 120 days, the Chairman of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Staff/Executive Committee.
- C. The Credentials Committee shall transmit to the Medical Staff/Executive Committee the complete application and its recommendation that the applicant be appointed to the Medical Staff, that his/her application be deferred for further consideration, or that he/she be rejected for Medical Staff appointment. The Chairman of the Credentials Committee or his/her designee shall be available to the Medical Staff/Executive Committee or any appropriate committee to answer any questions that may be raised with respect to the recommendation.

10.5 - Subsequent Action on the Application

- A. When the recommendation of the Credentials Committee is favorable to the applicant, they shall promptly forward it, together with all supporting documentation to the Medical Staff/Executive Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges. A favorable recommendation of the applicant by the Medical Staff/Executive Committee will be acted upon by the Board of Trustees at its next regularly scheduled meeting which shall not exceed thirty five (35) days after its receipt. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.
- B. When the recommendation of the Credentials Committee is to defer the application for further consideration, it must be followed up within 31 days by a subsequent recommendation to the Medical Staff/Executive Committee for appointment to the Medical Staff with specified clinical privileges, or for rejection of the application for staff appointment.
- C. When the recommendation of the Credentials Committee is adverse to the applicant in respect to either appointment to the staff or clinical privileges requested it shall be forwarded to the Medical Staff/Executive Committee together with all supporting documentation within 35 days. The applicant will be notified of the recommendation of the Medical Staff/Executive Committee. The CAO shall then hold the application until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Article IX, after which the CAO shall forward the recommendation of the Medical Staff/Executive Committee, together with the application and all supporting documentation, to the Board.

Section 11 - Procedure for Reappointment

11.1 - Application Procedure:

- A. Each current appointee who wishes to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form approved by the Board. The reappointment application shall be submitted to the CAO or his designee at least two months prior to the expiration of the appointee's then current appointment. Failure to submit an application will result in automatic expiration of the appointee's appointment and clinical privileges at the end of the then current medical staff year.
- B. This application shall include information pertaining to, but not limited to privileges and staff status desired for the coming year, as well as, information pertaining to the loss of clinical privileges at another institution and whether the applicant's membership in local, state or national professional societies of his license to practice any profession in any state, or his Drug Enforcement Administration license has been suspended, modified, terminated or voluntarily relinquished. The Medical Staff Office shall send to the Credentials Committee the list of those appointees desiring reappointment.
- C. An application for reappointment to the Medical Staff, or a request for revised clinical privileges, will be acted upon by the Credentials Committee, provided all necessary information can be obtained, within 60 days of receipt of the application or request.
- D. A favorable recommendation referable to the applicant or request for revised clinical privileges by the Credentials Committee will be acted upon by the Medical Staff Executive Committee at its next regularly scheduled meeting which shall not exceed thirty-five (35) days after which the recommendation was forwarded from the Credentials Committee.

- E. A favorable recommendation referable to the applicant or revised clinical privileges by the Medical Staff Executive Committee will be acted upon by the Board of Trustees at its next regularly scheduled meeting which shall not exceed thirty-five (35) days after which the recommendation was forwarded from the Medical Staff Executive Committee. Reappointment, if granted, shall be for a period of not more than three years. If an application for reappointment is filed and the Board has not acted on it prior to the expiration of the appointee's current appointment, the appointee's current appointment and clinical privileges shall continue in effect until such time as the Board acts on the reappointment application.

11.2 - Recredentialing Process- PI

The Quality Improvement Coordinator shall issue an Ongoing Periodic Performance Evaluation and/or a Focused Periodic Performance Evaluation to the Credentials Committee.

11.3 - Factors to be Considered

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff, or a change in staff category, where applicable, shall be based upon each appointee's:

- A. Ethical behavior, clinical competence and clinical judgment in the treatment of patients.
- B. Attendance at Medical Staff meetings and participating in staff duties. Compliance with the Hospital and Medical Staff Bylaws, Rules and Regulations and policies.
- C. Behavior in the Hospital, his/her cooperation with medical and Hospital personnel as it relates to patient care or the orderly operation of this Hospital, and his/her general attitude toward patients, the Hospital, and its personnel.
- D. Use of the Hospital's facilities for his/her patients.
- E. Physical and mental health.
- F. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment activities or other reasonable indicators of continuing qualifications.
- G. Satisfactory completion of such continuing education requirements as may be imposed by law, this Hospital, or applicable accreditation agencies.
- H. Other relevant findings from the Hospital's quality assessment activities.
- I. Information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance.
- J. Information on the citizenship and visa status of the applicant.
- K. Privileges and staff status desired for the coming year.
- L. Information pertaining to the voluntary or involuntary loss of clinical privileges of Medical Staff membership, a limitation, reduction or loss of privileges at another institution; and
- M. Information as to whether the applicant's membership in local, state or national professional societies, his/her license to practice any profession in any state or his/her Drug Enforcement Administration license has been suspended, modified, terminated or voluntarily relinquished.

11.4 - Credentials Committee Procedure

- A. The Credentials Committee shall review all pertinent information available including all information provided from other committees of the Medical Staff and from Hospital management for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.
- B. The Credentials Committee may require that a person currently seeking reappointment procure a physical and/or mental examination by a physician or physicians satisfactory to the Committee either as part of the reapplication process or during the appointment period to aid

in determining whether clinical privileges should be granted or continued and make results available for the Committee's consideration. Failure of the person seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee, shall constitute a voluntary relinquishment of all Medical Staff and clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

- C. The Credentials Committee shall prepare a list of persons currently holding appointment who are recommended for reappointment without change in staff category and clinical privileges. Recommendations for non-reappointment and for changes in category or privileges, with supporting data and reasons attached, shall be handled individually.
- D. The Credentials Committee shall transmit its report and recommendations to the Medical Staff/Executive Committee. The Medical Staff/Executive Committee shall then make its recommendations to the Board in time for the Board to consider reappointments at its final scheduled meeting in each reappointment cycle. Where non-reappointment, non-promotion of an eligible current appointee, or further limitation in clinical privileges is recommended; the reason for such recommendation shall be stated, documented and included in the report. This report shall not be transmitted to the Board until the affected staff appointee has exercised or has been deemed to have waived his/her right to a hearing as provided in Article IX. The Chairman of the Credentials Committee or his/her designee shall be available to the Medical Staff/Executive Committee to answer any questions that may be raised with respect to the recommendation.

11.5 - Meeting with Affected Individual

If during the process of a particular individual's reappointment, it become apparent to the Credentials Committee or its Chairman that the Committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairman of the Credentials Committee shall notify the individual of the general tenor of the possible recommendation, and ask him/her if he/she desires to meet with the Committee prior to any final recommendation by the Committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated, and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the Committee shall indicate as part of its report to the Executive Committee whether such a meeting occurred.

11.6 - Procedure Thereafter

Any recommendation by the Executive Committee denying reappointment, denying a requested change in staff category or clinical privileges shall entitle the affected individual to the procedural rights provided in Article VII. The CAO shall then promptly notify the individual of the recommendation by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived his/her right to a hearing as provided in Article IX, after which the Board shall be given the Committee's final recommendation and shall act on it. If for any reason the application for reappointment has not been finally acted on by the Board prior to the end of the appointment year, the then current appointment and clinical privileges shall continue until final action on the application is taken by the Board.

Section 12 - Denial, Non-renewal, Restriction, Suspension or Termination of Privileges

12.1 - Grounds for Action

Whenever, on the basis of information and belief, the Chief of Staff, the Chairman or a majority of any Medical Staff committee, the Chairman of the Board, or the CAO has a question referable to:

- A. The clinical competence of any Medical Staff appointee.
- B. The care or treatment of a patient or patients or management of a case by any Medical Staff appointee.
- C. The known or suspected violation by any Medical Staff appointment of applicable ethical standards, the AMA Model Medical Staff Code of Conduct, or the Bylaws, Policies, Rules and Regulations of the Hospital or its Board or Medical Staff, including, but not limited to the Hospital's quality assessment, risk management and utilization review programs.
- D. Behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive of the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others, a written request for an investigation of the matter shall be addressed to the Credentials Committee making specific reference to the activity or conduct which gave rise to the request.
- E. Harassment is defined as verbal or physical harassment that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, national origin, age, disability, marital status, citizenship or any other characteristic protected by law and is prohibited by this policy.
- F. Harassing conduct includes, but is not limited to: epithets or name calling, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written or graphic material that denigrates or shows hostility or aversion toward an individual or group that is placed on walls or elsewhere exhibited on Hospital premises.
- G. Sexual harassment; which is defined, as in the Equal Employment Opportunity Commission Guidelines, as unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature.
- H. When a formal concern is filed on any of the above items, the matter will be forwarded to the Medical Staff/Executive Committee.

12.2 - Investigative Procedure

The Credentials Committee shall meet as soon practicable after receiving the request and if, in the opinion of the Credentials Committee:

- A. The request for investigation contains information sufficient to warrant a recommendation, the Credentials Committee, at its discretion, shall make such a recommendation, with or without a personal interview with the appointee; or
- B. The request for investigation does not at that point contain information sufficient to warrant a recommendation, the Credentials Committee shall immediately investigate the matter, appoint a subcommittee to do so, or if it is deemed necessary, appoint an Investigating Committee.
- C. This Investigating Committee shall consist of three persons, who are members of the Active or Courtesy Medical Staff. This Committee shall not include partners, associates, or relatives of the affected individual or of any members of the Credentials Committee.

- D. The Credentials Committee or the Investigating Committee, if used, shall have available to them the full resources of the Medical Staff and the Hospital to aid in their work, as well as the authority to use outside consultants as required.
- E. The individual, with respect to whom an investigation has been requested, shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting, but not as a matter of right in advance of it, the individual shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the Credentials Committee.
- F. If an Investigating Committee is used, the Credentials Committee may accept, modify, or reject the recommendation it receives from that committee.

12.3 - Suspension of Privileges

At any time during the investigation, the Credentials Committee, with the approval of the CAO may suspend all or any part of the clinical privileges of the person being investigated. This suspension shall be deemed to be administrative in nature, for the protection of Hospital patients. It shall not indicate the validity of the charges, and shall remain in force, without appeal, during the course of the investigation. If such a suspension is placed into effect, the investigation shall be completed within thirty days of the suspension or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted.

12.4 - Procedure Thereafter

- A. In acting after the investigation, the Executive Committee may:
 - 1. Issue a written warning;
 - 2. Issue a letter of reprimand;
 - 3. Impose terms of probation;
 - 4. Impose a requirement for consultation;
 - 5. Recommend reduction of clinical privileges;
 - 6. Recommend suspension of clinical privileges for a term;
 - 7. Recommend revocation of staff appointment; or
 - 8. Recommend that no action is justified.
- B. Any recommendation by the Executive Committee for reduction of clinical privileges, for suspension of clinical privileges for a term of 14 days or more after the Credentials Committee acts, or for revocation of staff appointment shall entitle the affected individual to the procedural rights provided in Article IX. Such a recommendation shall be forwarded to the CAO who shall promptly notify the affected individual by certified mail, return receipt requested. The CAO shall then hold the recommendation until after the individual has been deemed to have waived his/her right to a hearing. The CAO shall then forward the recommendation of the Executive Committee, together with all supporting documentation, to the Board. The Chairman of the Executive Committee or his/her designee shall be available to the board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.
- C. If the action of the Credentials Committee is less severe than reduction of clinical privileges or suspension of clinical privileges for a term of month or more, or revocation of staff appointment, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefor shall be made

to the Board through the Chief of Staff, and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Executive Committee and such action would reduce clinical privileges; suspend clinical privileges for a month or more; or revoke staff appointment; it shall so notify the affected individual, through the CAO and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in Article IX.

- D. The Chairman of the Credentials Committee shall promptly notify the Executive Committee in writing of all requests for action regarding an individual received by the Credentials Committee and keep the CAO and Executive Committee fully informed of all action taken in connection therewith.

Article VII – Clinical Privileges

Section 1 -General

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Hospital. Each individual who has been given an appointment to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board, except as stated in policies adopted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal by the chairman of the department in which such privileges are sought. The Applicant shall have the burden of establishing his/her qualifications for and competence to exercise the clinical privileges he/she requests. Recommendations of the clinical departments in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application for staff appointment.

Practitioners initially appointed to the Medical Staff and granted clinical privileges shall be provided with a copy of the Medical Staff Bylaws and the Rules & Regulations.

Section 2 – Delineation of Privileges

Each department or committee of the medical staff shall be required to draft a delineation of all possible privileges available to practitioners in that department with guidelines as to the level of training and expertise required for the granting of any such privileges. These delineations shall be adopted as rules and regulations of the medical staff after approval by the MEC and the Hospital governing board.

Section 3 - Dental Privileges

The scope and extent of surgical procedures that a dentist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chairman of Surgery. A medical history and physical examination for all dental admissions shall be performed and recorded by a physician who holds an appointment to the Medical Staff, and the designated physician shall be responsible for the medical care of the patient throughout the period of Hospitalization.

Oral surgeons shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws.

Members of the dental staff shall not be required to attend staff meetings except as specified in the Bylaws.

Section 4 - Allied Health Provider Privileges

4.1 - Podiatrist Privileges

The scope and extent of surgical procedures that a podiatrist may perform in this Hospital shall be delineated and recommended to the Board in accordance with the provisions of these Bylaws governing Medical Associates and such policies may be adopted by the Board from time to time. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery. A medical history and physical examination of the patient shall be performed and recorded in the medical record by a physician who holds an appointment to the Medical Staff before podiatric surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of Hospitalization. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his/her license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws.

4.2 - Other AHP Privileges

The scope and extent of the clinical privileges which may be awarded to CRNA's, social workers, psychologists, speech therapists, physical therapists and other licensed medical associates shall be delineated and recommended to the Board in accordance with the provisions of these Bylaws governing medical associates, and such policies may be adopted by the Board from time to time. These medical associates may not write orders on Hospitalized patients unless countersigned by the physician primarily responsible for the care of the patient.

However, a CRNA may utilize medications and perform procedures within the scope of his/her license as long as it is consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws.

Section 5 – Residents and Medical Students

Interns and Residents in training in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those privileges set out in the training protocols developed by the Executive Committee.

Medical Students, who are participants in the Methodist Hospital/PCSOM Core Site training program, shall be permitted to exercise only those privileges set out in the approved training protocol.

Medical Students, Nursing Students and Physician Assistant Students can write orders under the direct supervision of a preceptor; however, the orders will not be honored by nursing service until the orders are signed by the preceptor.

Section 6 – Notification of Final Board Action

Each applicant for initial appointment, reappointment, or with a change of clinical privileges, shall be notified of final Board action by the Medical Staff Office in a written communication.

Section 7 – Temporary Privileges

- A. In extraordinary situations, when necessary, to avoid undue hardship to the applicant, the CAO may, upon the basis of verified information then available which may reasonably be relied upon as to the licensure, competence, character, ethical standing, proof of alternate coverage, and malpractice insurance coverage of the applicant, and after consulting with the Chief of Staff may grant temporary admitting and clinical privileges to an applicant for a specific time period not to exceed 30 days, provided that his/her application has been determined to be complete. In exercising such privileges, the applicant shall act under the supervision of the Chief of Staff. If all requested information, referable to the applicant has not been received; and, after appropriate review, temporary privileges may be extended for another 30 days by the same mechanism for the granting of the original temporary privileges.
- B. When a physician has made application for Active Medical Staff membership and temporary privileges have been granted for a specific time period, this time period will be applied to the six month probationary period required for Associate/Active Medical Staff.
- C. Special requirements of supervision and reporting may be imposed by the Chief of Staff on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the CAO or his/her designee upon notice of any failure by the individual to comply with such specific conditions.

Section 8 – Termination of Temporary Clinical Privileges

- A. The CAO, or in his/her absence, his/her designee, may at any time, after asking for a recommendation from the Chief of Staff terminate an individual's temporary admitting privileges. Clinical privileges shall then be terminated when the physician's in-patients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary clinical privileges may be imposed by the CAO or Chief of Staff, and such termination shall be immediately effective.
- B. The Chief of Staff shall assign a Medical Staff appointee the responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.
- C. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Neither the granting, denial, nor termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.
- D. Temporary privileges shall be automatically terminated at such time as the Medical Staff/Executive Committee recommends unfavorably, with respect to the applicant's appointment to the staff, or at the Executive Committee's discretion, shall be modified to conform to the recommendation of the Credentials Committee that the applicant be granted different permanent privileges from the temporary privileges.

Section 9 – Locum Tenens

The CAO may grant an individual serving as a locum tenens, for a person holding an appointment to the Medical Staff, temporary admitting and clinical privileges to attend patients of that appointee for a period not to exceed 15 days. This shall be done in the same manner and upon the same conditions as set forth in section 6 of this part, provided that the CAO first obtain such individual's signed acknowledgment that he/she has received and had an opportunity to read copies of the Hospital and Medical Staff Bylaws Rules and Regulations which are then in force, and that he/she agrees to be

bound by the terms thereof in all matters relating to his/her temporary clinical privileges. The individual serving as a locum tenens must also complete a request for clinical privileges form and must have in force and effect professional liability insurance in an amount acceptable to the Hospital.

Section 10 – Emergency Privileges

- A. In an emergency involving a particular patient, a physician who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges to act in such emergency using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable.
- B. Similarly, in an emergency involving a particular patient, a physician currently appointed to the Medical Staff may be permitted by the Hospital to act in such emergency by exercising clinical privileges not specifically assigned to him/her.
- C. When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or he/she does not request such privileges, the patient shall be assigned by the Chief of Staff or his/her designee to an appropriate person currently appointed to the Medical Staff. The wishes of the patient shall be considered in the selection of a substitute physician.

Section 11 – Disaster Privileges

- A. When an emergency management plan is implemented by the Hospital and the organization is unable to meet immediate patient needs, volunteer LIP's (Licensed Independent Practitioner) may be granted emergency (temporary) privileges as desired below. During a disaster, the following may grant emergency privileges:
 - CAO
 - Chief of Staff
 - Any of the above noted individuals may designate a designee to act in their absence.
- B. The granting of emergency privileges will be made on a case by case basis. At no time will any of the above identified individuals be required to grant privileges to any individual LIP.
- C. The credentials verification process, unless there are extraordinary circumstances (e.g. no means of communication), primary source verification of licensure shall begin as soon as the immediate situation is under control and be completed within 72 hours from the time the volunteer licensed independent practitioner presents to the Hospital. In extraordinary circumstances in which the verification cannot be completed within 72 hours, there must be documentation of the following:
 - 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
 - An attempt to rectify the situation as soon as possible
- D. In granting these emergency privileges, the individuals noted above should review any of the following available information about the LIP in question. Emergency privileges may be granted upon presentation of any of the following:
 - Current Hospital photograph
 - Current photograph issued by a state, federal or regulatory agency
 - Current license to practice, granted by a federal, state or regulatory agency
 - ID individual LIP is a member of Disaster Medical Assistant Team (DMT)

- ID indicating LIP has been granted authority to render patient care in an emergency circumstance by a federal, state or municipal entity
 - Personal (first-hand) knowledge of the LIP's identity presented by a current Medical Staff member.
- E. Any LIP granted privileges under the above circumstances shall act in accordance with the Medical Staff Bylaws and be answerable to the Board through the Chief of Staff.
- F. The licensed independent practitioner with disaster privileges shall be overseen by the Operations Section Chief. If circumstances do not allow for a mentor or direct observation, the clinical notes made by the licensed independent practitioner with disaster privileges will be immediately reviewed by a member of the Medical Staff with appropriate privileges when the disaster has ended. In all events, the Medical Staff is responsible for overseeing the professional practice of volunteer licensed independent practitioners.
- G. If the disaster still exists 72 hours after the initial disaster privileges were granted, the CAO or his/her designee may extend a licensed independent practitioner's privileges for another 72 hours. Such extension will be based upon the information obtained and documented by the Medical Staff's direct or indirect observations.
- H. These disaster privileges shall automatically terminate upon the abatement of the disaster with respect to the type of services provided by the licensed independent practitioner granted disaster privileges hereunder, as determined by Administration or the Governing Board, or the de-activation of the emergency management plan that gave rise to the licensed independent practitioner being granted privileges.

Section 12 – Request of Increase of Clinical Privileges

12.1 - Application for Increased Clinical Privileges:

Whenever, during the term of his/her appointment to the Medical Staff, an individual desires to increase his/her clinical privileges, he/she shall apply in writing to the Executive Committee on a form approved by the Board. The application shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justify increased privileges. This application will be transmitted by the CAO to the Credentials Committee. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as part of the reappointment application, if the request is made at that time.

12.2 - Factors to be Considered:

Recommendations for increase or decrease of clinical privileges shall be based upon:

- Relevant recent training;
- Observation of patient care provided;
- Review of the records of patients treated in this or other Hospitals;
- Results of the Hospital's quality assessment activities; and
- Other reasonable indicators of the individual's continuing qualifications for the privileges in question.

The recommendation for such privileges may carry with it such requirements for supervision or Consultation for such period of time as is deemed necessary.

Article VIII – Corrective Action

Section 1 – Grounds for Action

Whenever, on the basis of information and belief, the Chief of Staff; the Chairman or a majority of any Medical Staff committee; the Chairman of the Board; or the CAO has a question referable to:

- A. The clinical competence of any Medical Staff appointee;
- B. The care or treatment of a patient or patients or management of a case by any Medical Staff appointee;
- C. The known or suspected violation by any Medical Staff appointment of applicable ethical standards, the AMA Model Medical Staff Code of Conduct, or the Bylaws, Policies, Rules and Regulations of the Hospital or its Board or Medical Staff, including, but not limited to the Hospital's quality assessment, risk management and utilization review programs; or
- D. Behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive of the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others, a written request for an investigation of the matter shall be addressed to the Credentials Committee making specific reference to the activity or conduct which gave rise to the request.
- E. Harassment is defined as verbal or physical harassment that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, national origin, age, disability, marital status, citizenship or any other characteristic protected by law and is prohibited by this policy.
- F. Harassing conduct includes, but is not limited to: epithets or name calling, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written or graphic material that denigrates or shows hostility or aversion toward an individual or group that is placed on walls or elsewhere exhibited on Hospital premises.
- G. Sexual harassment; which is defined, as in the Equal Employment Opportunity Commission Guidelines, as unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature.
- H. Failure to certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at the Hospital, and conflicts of interest; failure to document compliance on request; and/or violation of such statutes, regulations or policies.

When a formal concern is filed on any of the above items, the matter will be forwarded to the Medical Staff/Executive Committee.

Section 2 – Investigative Procedure

- A. The Credentials Committee shall meet as soon after receiving the request as practicable and if, in the opinion of the Credentials Committee:
 - 1. The request for investigation contains information sufficient to warrant a recommendation, the Credentials Committee, at its discretion, shall make such a recommendation, with or without a personal interview with the appointee; or
 - 2. The request for investigation does not at that point contain information sufficient to warrant a recommendation, the Credentials Committee shall immediately investigate the matter, appoint a subcommittee to do so, or if it is deemed necessary, appoint an Investigating Committee.

3. This Investigating Committee shall consist of three persons, who are members of the Active/Courtesy Medical Staff. This Committee shall not include partners, associates, or relatives of the affected individual or of any members of the Credentials Committee.
4. The Credentials Committee or the Investigating Committee, if used, shall have available to them the full resources of the Medical Staff and the Hospital to aid in their work, as well as the authority to use outside consultants as required.
5. The individual, with respect to whom an investigation has been requested, shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting, but not as a matter of right in advance of it, the individual shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the Credentials Committee.
6. If an Investigating Committee is used, the Credentials Committee may accept, modify, or reject the recommendation it receives from that committee.

Section 3 – Procedure Thereafter

- A. In acting after the investigation, the Executive Committee may:
 1. Issue a written warning;
 2. Issue a letter of reprimand;
 3. Impose terms of probation;
 4. Impose a requirement for consultation;
 5. Recommend reduction of clinical privileges;
 6. Recommend suspension of clinical privileges for a term;
 7. Recommend revocation of staff appointment; or
 8. Recommend that no action is justified.
- B. Any recommendation by the Executive Committee for reduction of clinical privileges, for suspension of clinical privileges for a term of 14 days or more after the Credentials Committee acts, or for revocation of staff appointment shall entitle the affected individual to the procedural rights provided in Article XII. Such a recommendation shall be forwarded to the CAO who shall promptly notify the affected individual by certified mail, return receipt requested. The CAO shall then hold the recommendation until after the individual has been deemed to have waived his/her right to a hearing. The CAO shall then forward the recommendation of the Executive Committee, together with all supporting documentation, to the Board. The Chairman of the Executive Committee or his/her designee shall be available to the board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.
- C. If the action of the Credentials Committee is less severe than reduction of clinical privileges or suspension of clinical privileges for a term of month or more, or revocation of staff appointment, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefor shall be made to the Board through the Chief of Staff, and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Executive Committee and such action would reduce clinical privileges; suspend clinical privileges for a month or more; or revoke staff appointment; it shall so notify the affected individual, through the CAO and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in Article XII.

- D. The Chairman of the Credentials Committee shall promptly notify the Executive Committee in writing of all requests for action regarding an individual received by the Credentials Committee and keep the CAO and Executive Committee fully informed of all action taken in connection therewith.

Section 4 – Suspension of Privileges

At any time during the investigation, the Credentials Committee, with the approval of the CAO may suspend all or any part of the clinical privileges of the person being investigated. This suspension shall be deemed to be administrative in nature, for the protection of Hospital patients. It shall not indicate the validity of the charges, and shall remain in force, without appeal, during the course of the investigation. If such a suspension is placed into effect, the investigation shall be completed within thirty days of the suspension or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted.

Section 5 – Ground for Suspension

- A. The Chief of Staff, the CAO or in his/her absence his/her designee, or the Chairman of the Board shall each have the authority to summarily suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever such action is in the best interest of patient care or safety or the continued effective operation of the Hospital or whenever such individual has violated the Bylaws, Rules, Regulations and Policies of the Hospital or Medical Staff. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.
- B. Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CAO in his/her absence, his/her designee and the Chief of Staff, and shall remain in effect unless or until modified by the CAO or the Board.

Section 6 – Credentials Committee Procedure

Any person who exercises his/her authority under Section 5 of Article VIII to summarily suspend clinical privileges shall immediately report his/her action to the Chairman of the Executive Committee to take further action in the matter. At that point the Committee shall take such further action as is required in the manner specified under Section 2 through Section 5 of this Article. The summary suspension shall remain in force after the appropriate committee takes responsibility unless and until modified by that committee or the CAO or until the matter that required the suspension is finally resolved.

Section 7 – Care of Suspended Individual's Patients

Immediately upon the imposition of a summary suspension, the Chief of Staff, shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the Hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered in the selection of a substitute. It shall be the duty of the Chief of Staff to cooperate with the CAO in enforcing all suspensions.

Section 8 – Action by State Licensing Agency

Action by the appropriate state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in automatic relinquishment of all Hospital clinical privileges as that date, until the matter is resolved and the license restored.

Section 9 – Failure to be Adequately Insured

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect, the appointee's clinical privileges shall be voluntarily relinquished as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

Section 10 – Failure to Attend Meetings or Satisfy Continuing Education

Requirements

- A. Failure to attend meetings as required in these Bylaws Rules and Regulations or failure to complete mandated continuing education requirements imposed by the Kentucky State License Agency shall be considered a voluntary relinquishment of Medical Staff appointment and shall be sufficient grounds for refusing to reappoint the individual concerned. Such failures shall be documented and specifically considered by the Executive Committee when making its recommendations for reappointment and by the Board when making its final decisions.
- B. Any individual whose reappointment has been refused for these reasons shall be entitled to meet with a committee to be designated by the Board before final action is taken. This meeting with the Board committee shall be conducted under the procedural rules provided in these Bylaws.
- C. If reappointment is refused by the Board, the individual shall be eligible to reapply for staff appointment and the application shall be processed in the same manner as if it were an initial application.

Section 11 – Penalty for Violation of Bylaws and Rules and Regulations

Any physician on the Medical Staff who has been dismissed from the staff three times in one year due to violations of the Rules and Regulations or Bylaws, shall lose his admitting and clinical privileges for period of two weeks without retribution. It shall be his responsibility to provide for another physician to admit and provide care for his patients during that period of time. Following that two week period, he shall be allowed to reapply for full privileges as provided by Article IX of these Bylaws.

Article IX – Hearing and Appeal Procedures

Section 1 – Purpose

An applicant or an individual holding a Medical Staff appointment shall be entitled to a hearing whenever a recommendation unfavorable to him/her has been made by the Executive Committee regarding those matters enumerated in Section 2 of this Article. In the event the Board should determine to reject a favorable recommendation by the Executive Committee regarding any of those matters, the affected individual shall also be entitled to a hearing before the Board enters a final decision. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital Corporation, whether Medical Staff or Board, and the duties of the Hearing Panel shall be so defined and so carried out. Accordingly, the hearing shall be conducted in as informal a manner as possible, subject only to the rules and procedures set forth in these Bylaws.

Section 2 – Actions That Entitle a Practitioner to a Hearing

2.1 - Grounds for Hearing

No recommendation or action other than those hereinafter enumerated shall constitute grounds for a hearing:

- A. Denial of initial Medical Staff appointment.
- B. Denial of requested advancement in Medical Staff category.
- C. Denial of Medical Staff reappointment.
- D. Revocation of Medical Staff appointment.
- E. Denial of requested initial clinical privileges.
- F. Denial of requested increased clinical privileges.
- G. Decrease of clinical privileges.
- H. Suspension of total clinical privileges for a term of a month or more.

2.2 - Unappealable Actions

Neither voluntary nor automatic relinquishment of clinical privileges, as provided for elsewhere in these Bylaws, nor the imposition of any consultation requirement, nor the imposition of a requirement for retraining, additional training or continuing education, no matter whether imposed by the Executive Committee or the Board, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

Section 3 – Notice of Adverse Action

When a recommendation is made which, according to these Bylaws, entitles an individual to a hearing prior to a final decision of the Board on that recommendation, the affected individual shall promptly be given notice by the CAO, in writing, return receipt requested. This notice shall contain a statement of the recommendation made, “the reasons for the recommendation, and the right to request a hearing on the recommendation. Additionally, the notice shall contain a summary of the rights in the conduct of the hearing.”

Section 4 – Request for Hearing

Such individual shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing by the Hearing Panel hereinafter referred to, said request being made by written notice to the CAO. In the event the affected individual does not request a hearing within the time and in the manner herein- above set forth, he/she shall be deemed to have waived his/her right to such hearing and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

Section 5 – Hearing Panel

When a hearing is requested, the CAO acting for the Board and after considering the recommendations of the Chief of Staff and the Chairman of the Board, shall appoint a Hearing Panel which shall be composed of not less than three members. The majority of the Panel shall be composed of Medical Staff appointees who shall not be in economic competition with the physician involved and shall not have actively participated in the consideration of the matter involved at any previous level or physicians not connected with the Hospital or a combination of such persons. Such appointment shall include designation of the Chairman. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

5.1 - Hearing Officer

- A. The CAO may appoint any attorney at law as Hearing Officer. Such Hearing Officer may not be legal counsel to the Hospital. He/she must act as a prosecuting officer, or as an advocate for either side at the hearing. He/she may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but he/she shall not be entitled to vote on its recommendations. He/she may thereafter continue to advise the Board on the matter.
- B. If no Hearing Officer has been appointed, the Chairman of the Hearing Panel shall be the Hearing Officer.
- C. The Hearing Officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He/she shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which he/she may be advised by legal counsel to the Hospital. In all instances, he/she shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the Hearing Officer is acting at all times to see that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Board.

5.2 - Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

5.3 - Admissibility of Evidence

This hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.

5.4 - Official Notice

The Hearing Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

5.5 - Attendance by Panel Members

Recognizing that it may not be possible for all members of the Hearing Panel to be present continually at all sessions of the panel, since it is necessary to conduct a hearing as soon as

reasonable after the event or events that gave rise to its necessity, the hearing shall continue even though certain members of the Hearing Panel are not present at all times. The fact that certain panel members were not physically present at all times during the hearings will not disqualify them or invalidate the hearing. Consequently, no quorum of the Hearing Panel shall be required in order to continue the hearing. The vote shall be by majority of those appointed to the Hearing Panel.

Section 6. Hearing Rights

6.1 - Notice of Hearing and Statement of Reasons

The CAO shall schedule the hearing and shall give notice, in writing, return receipt requested to the person who requested the hearing of its time, place, date and list of witnesses expected to be called by the Medical Staff or Hospital at the hearing. The hearing shall begin within thirty (30) days. This notice shall contain a statement of the reasons for the recommendation as well as the patient records and information supporting the recommendation. This statement and the patient records and information it contains may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and his/her counsel have sufficient time to study this additional information and rebut it.

6.2 - Representation

The individual requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine witnesses and present his/her case. He/she shall inform the CAO in writing of the name of that person at least ten days prior to the date of the hearing. The CAO shall appoint a person, who may be an attorney, to support the recommendations that gave rise to the hearing and to examine and cross-examine witnesses at the hearing.

6.3 - Rights of Both Sides

At a hearing, both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, and to rebut any evidence. If the person requesting the hearing does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination. Further, the physician shall have a right to submit a written statement at the close of the hearing.

6.4 - List of Witnesses

If either party, by notice, requests a list of witnesses, then each party within ten days of such request shall furnish to the other a written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing, and the names and addresses of additional witnesses as soon as procured. The witness list of either party may at any time during the course of the hearing be changed, provided that notice of the change is given to the other party.

6.5 - Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

6.6 - Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone, but shall be permitted only by the Hearing Panel or its Hearing Officer on a showing of good cause.

6.7 - Adjournment and Conclusion

Upon the adjournment of the hearing, the physician involved has the right to:

- A. Receive the written recommendation of the presiding officer including a statement of the basis of the recommendations and;
- B. To receive a written decision of the healthcare entity, including a statement of the basis for the decision.

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Section 7. Burden of Proof

At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

- A. The Board or the Executive Committee, whichever recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in his/her support.
- B. After the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Board unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

Section 8. Conduct of the Hearing

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

- A. Oral testimony of witnesses.
- B. Memorandum of points and authorities presented in connection with the hearing.
- C. Any information regarding the person who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it.
- D. Any and all applications, references and accompanying documents.
- E. All officially noticed matters.
- F. Any other evidence that has been admitted.

Section 9. Hearing Panel Recommendation

9.1 - Deliberations and Recommendations of the Hearing Panel

Within twenty days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Hearing Officer and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report to the CAO.

9.2 - Disposition of Hearing Panel Report

Upon its receipt, the CAO shall forward the Hearing Panel's report and recommendation, along with all supporting documentation, to the Board for further action. He/she shall also send a copy of the report and recommendation, return receipt requested, to the individual who requested the hearing. If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, a copy of the report of the Hearing Panel shall be delivered by the CAO to the committee for informational purposes.

Section 10. Appellate Review

10.1 - Time For Appeal

Within ten (10) days after the affected individual is notified of an adverse recommendation from the Hearing Panel or Board Committee modifying a recommendation of a hearing panel which was not appealed in a manner adverse to the individual, he/she may request an appellate review. The request shall be in writing, and shall be delivered to the CAO either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, the affected individual shall be deemed to have accepted the recommendation involved, and it shall thereupon become final and immediately effective.

10.2 - Grounds For Appeal

The grounds for appeal from an adverse recommendation shall be that:

- A. There was substantial failure on the part of the Executive Committee, Hearing Panel, or Board Committee, whichever recommendation is the subject of the appellate review, to comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or
- B. The above recommendations were made arbitrarily, capriciously, or with prejudice; or
- C. The above recommendations were not supported by the evidence.

10.3 Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding sections, the Chairman of the Board shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause the affected individual to be given notice of the time, place and date of the appellate review. The date of appellate review shall be not be less than 20 days, nor more than 40 days, from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board for good cause.

10.4 - Nature of Appellate Review

- A. The Chairman of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, or any combination of the same, to consider the record upon which the pending recommendation was made.
- B. The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that

he/she was deprived of the opportunity to admit it at the hearing and then only at the discretion of the Review Panel.

- C. Each party shall have the right to present a written statement in support of his/her position on appeal, and in its sole discretion, the Review Panel may allow each party or his/her representative to appear personally and make oral argument. The Review Panel shall recommend final action to the Board.
- D. The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

10.5 - Final Decision of The Board

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the Chairman of the Executive Committee, in person or by certified mail.

10.6 - Further Review

Except where the matter is referred for further action and recommendation in accordance with Section 10.4, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed 30 days in duration except as the parties may otherwise stipulate.

10.7 - Right To One Appeal Only

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Executive Committee or Hearing Panel, or a combination of acts of such bodies. In the event that the Board ultimately determines to deny initial appointment or reappointment to the Medical Staff to an applicant or revoke or terminate the Medical Staff appointment and clinical privileges of a current appointee, that individual may not again apply for Medical Staff appointment or clinical privileges at this Hospital unless the Board provides otherwise. However, nothing in these Bylaws shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of an appointee to apply for reappointment and clinical privileges after the expiration of five years from the date of such Board decision unless the Board provides otherwise in its written decision.

Article X – Structure of the Medical Staff

The Medical Staff is the formal organization of practitioners who have been appointed to the Medical Staff by the Governing Board and who are granted clinical privileges at the Hospital. The Organized Medical Staff is responsible for carrying out those responsibilities assigned by the Governing Board through these Bylaws, including oversight of the quality of medical care, professional performance, credentialing and privileging recommendations, peer review activities, and the development and enforcement of Medical Staff Bylaws, Rules and Regulations.

Section 1 – Authority

The Medical Staff shall exercise those powers and responsibilities granted by the Governing Board and shall act through its officers, the Medical Executive Committee, standing committees, and the Medical Staff as assembled in regular or special meetings.

Section 2 – Relationship to the Governing Board

The Medical Staff serves in an advisory capacity to the Governing Board on matters relating to the quality of patient care, clinical competence, credentialing, privileging, and professional practice. Final authority for appointment, reappointment, and the granting, modification, or revocation of clinical privileges rests with the Governing Board.

Section 3 – Committees

The Medical Staff shall carry out its responsibilities through the Medical Executive Committee and such standing and special committees as described in these Bylaws.

All committees shall meet at least bimonthly, unless otherwise specified, at a time set by the members of the committee. The agenda for the meeting and its general conduct shall be set by the chairman.

Article XI – Officers

The Officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer. Officers must be appointed to the Active Staff at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 1- The Chief

- A. The Chief, Medical Staff is the professional or clinical head of the Medical Staff and as such, is the duly elected medical representative of the Medical Staff from the Board. He is directly involved with the proper organization and functioning of the Medical Staff of the hospital.
- B. The Chief of Staff shall be nominated by the Executive Committee of the Medical Staff by vote of all Medical Staff members at their last meeting of the calendar year. The nomination for Chief of Staff shall be sent to the Board for approval. If the Board rejects this nomination, the Executive Committee shall be required to nominate another Chief of Staff, or shall be required to submit a list of two or three names from which the Board may select a Chief of Staff. In the event of controversy between the Executive Committee and Governing Board should make every attempt to reach an amicable solution before final appointment is made; however, the final selection of a Chief of Staff shall be the duty of the Board. If the office of Chief of Staff should become vacant before the expiration of a full term, a successor shall be chosen to fill the unexpired term using the same procedures which were used originally to select the Chief of Staff.
- C. The term of office of the Chief of Staff shall be for one (1) year. There shall be no limit to the number of times which an individual may be re-elected to this office.
- D. A Chief of Staff, who is demonstrably unable or unwilling to fulfill his/her duties, or who by his/her conduct brings distress or dishonor upon this Corporation, may be removed from the office by a two-thirds (2/3) vote of the members of the Board present at any meeting of the Board acting upon the prior written recommendation of the Executive Committee .
- E. The Chief of Staff shall have direct responsibility for the organization and administration of the Medical Staff, in accordance with the terms of the existing Bylaws. In all medical-administrative matters, he/she shall act together with the CAO of the Hospital in implementing the adopted policies of the Board.
- F. The Chief of Staff shall be responsible to the Board through the CAO for a program to assure high-quality medical care in the Hospital. He/she should be responsible for the processes of

supervision, control, and appraisal necessary to assure the standards of medical care affirmed by the Board.

- G. The Chief of Staff shall, at the regular meetings of the Board, submit to it a clinical report containing all information relevant to an appraisal of the medical care provided in the Hospital.
- H. The Chief of Staff shall convey to the Board the recommendations of the Executive Committee respecting appointments and reappointments to the Medical Staff; granting or restricting clinical privileges of individual physicians; disciplinary action against individual physicians; or amendments or additions to the Medical Staff Rules and Regulations. He/she shall, on invitation, advise the Board on these recommendations.
- I. The Chief of Staff shall be a member, ex-officio, of all committees of the Medical Staff and shall call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff. He/she shall be responsible for the proper functioning of all committees of the Medical Staff in accordance with the requirements set forth in the Medical Staff Bylaws and consistent with the policies of the Board in assuring the highest possible control of the standards of medical care in the Hospital.
- J. The Chief of Staff shall be responsible for the enforcement of the Medical Staff Rules and Regulations, for implementation of sanctions where these are stipulated for non-compliance and for presentation to the Executive Committee of those cases where disciplinary action may be recommended to the Board.
- K. The Chief of Staff shall have the authority to temporarily suspend or restrict the privileges of any staff physician in case of extreme and immediate necessity. Knowledge of such action shall be conveyed immediately to the Hospital CAO. Such suspensions or restrictions shall be made only to meet emergencies, not for purposes of discipline, and shall prevail only until appropriate action can be taken by the CAO or the Board. Where the condition causing the temporary suspension or restriction of privileges is of a temporary nature, the CAO may remove the suspension or restriction when to the best of his/her knowledge the condition causing the suspension or restriction ceases to exist. The Board shall be informed of both the suspension or restriction of privileges and the removal of the suspension or restriction of privileges.
- L. When a physician has had his/her Hospital privileges restricted or suspended, the Chief of Staff shall arrange for the care of that doctor's patients who are then in the Hospital.

Duties:

- A. Preside at and be responsible for the agenda of all general meetings of the Medical Staff.
- B. Make appointment of Committee Chairmen and members in accordance with provisions of the bylaws, to all standing, special, and ad hoc medical staff committees, except the Executive Committee.
- C. Serve as an ex-officio member of all medical staff committees other than the Executive Committee.
- D. Work closely with the Chief of Staff and CAO of the hospital in carrying out all provisions of the Bylaws Rules and Regulations.
- E. Work closely with the Chief of Staff and the CAO of the hospital to help provide day to day liaison of all Medical Staff matters involving both the Medical Staff and the Board.

Section 2 – Vice Chief of Staff

The Vice Chief of Staff shall:

- A. Assume all duties and have the authority of the Chief of Staff in the event of his/her temporary inability to perform due to illness, being out of the community, or being unavailable for any other reason.
- B. Be a member of the Executive Committee of the Medical Staff.

- C. Automatically succeed the Chief of Staff when he/she fails to serve for any reason.
- D. Perform such duties as are assigned to him/her by the Chief of Staff.
- E. Should the Chief of Staff and the Vice Chief of Staff be unavailable in any emergency, the authority and duties of the Chief will be temporarily assumed by the immediate past Chief.

Section 3 – The Secretary-Treasurer

The Secretary-Treasurer shall:

- A. Serve on the Executive Committee.
- B. Keep accurate and complete minutes of all meetings, record attendance, and give notice of all meetings on order of the Chief of Staff and perform such other duties as the Chief of Medical Staff shall assign to him/her.

Section 4 - Election of Officers

If so instructed by the full Medical Staff, at least two months before the scheduled date of the next Medical Staff election, the Chief of Staff shall appoint a Nominating Committee consisting of three Active Staff appointees. The Nominating Committee shall prepare a slate of nominees for each office.

Nominations for officers of the Medical Staff may be presented by the Nominating Committee and made from the floor at each annual meeting. The candidates who receive a majority vote, of those Medical Staff appointees eligible to vote and present at the meeting at the time the vote is taken, shall be elected. Each newly elected officer shall serve from the start of the next Medical Staff year for a term of one year or until his/her successor has been elected.

In any election, if there are three or more candidates for an office, and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.

Section 5 – Removal of Officers

The Medical Staff, by a two-thirds majority vote, may remove any Medical Staff officer for conduct detrimental to the interests of the Hospital, or if he/she is suffering from a physical or mental infirmity that renders him/her incapable of fulfilling the duties of his/her office, providing notice of the meeting at which such action takes place shall have been given in writing to such officer at least ten days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in his/her own behalf prior to the taking of any vote on his/her removal.

Section 6 – Vacancies in Office

If there is a vacancy in the office of the Chief of Staff prior to the expiration of his/her term, the Vice Chief of Staff shall assume the duties and authority of the Chief of Staff for the remainder of the unexpired term. If there is a vacancy in any other office, the Medical Staff shall elect another Active Staff appointee to serve out the remainder of the unexpired term. Such appointment will be effective immediately.

Article XII – Clinical Departments

Deaconess Union County Hospital is a non-departmentalized Hospital.

Article XIII –Committees of the Medical Staff

Section 1 – Purpose

The Medical Executive Committee and the other committee of the Medical Staff assist the Medical Staff in carrying out its responsibilities for the quality of patient care, credentialing and privileging, professional practice evaluation, performance improvement, and other functions delegated by these Bylaws.

Section 2 – Committee Appointments

2.1 - Chairmen

- A. All committee chairmen, unless otherwise provided for in these Bylaws, will be appointed by the Chief of Staff. All chairmen shall be selected from among persons appointed to the Active Medical Staff or as need from the Courtesy Medical Staff.
- B. Such appointments will be made by the Chief of Staff within 30 days following the annual full Medical Staff meeting, for a term of one year.

2.2 - Members

- A. Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the newly appointed Chief of Staff, not more than 30 days after the annual full Medical Staff meeting, with no limitation in the number of terms they may serve.
- B. All appointed members may be removed and vacancies filled by the Chief of Staff at his/her discretion.
- C. The CAO and the Chief of Staff shall be members, ex-officio, on all committees.
- D. All appointments of Hospital personnel to the Medical Staff committees shall be made by the CAO. All Hospital personnel, so named, shall serve on these committees in an ex-officio capacity.
- E. All Medical Staff committees, with the exception of MEC, may conduct meetings with only one (1) physician member present. Committee recommendations, approvals, etc. will be referred to MEC for approval.

Section 3 – Medical Executive Committee

3.1 - Composition

The Medical Executive Committee shall consist of the officers of the Medical Staff elected by the Active or Courtesy Medical Staff, and the chairman of each appointed committee.

The Chief of Staff shall be the Chairman of the Executive Committee.

The CAO may attend meetings of the MEC and participate in its discussions but without vote.

3.2 - Rules of Orders

Wherever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

3.3 - Duties

The duties of MEC shall be:

- A. To represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the staff, between meetings of the Medical Staff, subject only to any limitations imposed by these bylaws;

- B. To coordinate the activities and general policies of the various services;
- C. To receive and act upon committee reports, and to make recommendations concerning them to the CAO and the Board;
- D. To implement policies of the Medical Staff that are not the responsibility of the department;
- E. To provide liaison among the Medical Staff, the CAO and the Board;
- F. To keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the hospital;
- G. To enforce hospital and Medical Staff rules in the best interest of patient care and of the hospital on the part of all persons who hold appointment to the Medical Staff;
- H. To refer situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointees to the Credentials Committee for appropriate action in accordance with Article XI.
- I. To be responsible to the Board for the implementation of hospitals quality assessment plan as it affects the Medical Staff;
- J. To determine minimum continuing education requirements for appointees to the staff;
- K. To nominate and recommend annually to the Board of the hospital a member of the Active Medical Staff to serve as Chief of Staff.

3.4 - Combined Meetings

For administrative efficiency, the MEC and the Medical Staff may meet in combined session.

The MEC and Medical Staff shall hold regular bi-month meetings, on the Hospital premises and via electronic link, for the purpose of reviewing and evaluating service and committee reports and recommendations, and to act on any other matters placed on the agenda by the Chief of Staff. MEC and Medical Staff shall be held on the third Wednesday at 12 noon beginning in February of each year. In the event the third Wednesday falls on a holiday, the meeting shall be held on the following fourth Wednesday at the same time and place as specified at the regular meetings of the Medical Staff. The Chief of Staff may call a special meeting as deemed necessary to conduct business of the Medical Staff.

3.5 - Annual Medical Staff Meeting

The Medical Staff at the November meeting shall hold its annual meeting at which officers for the ensuing year shall be elected. All committee assignments and staff appointments shall be made not more than thirty (30) days following the annual meeting.

3.6 - Agenda

The agenda at any regular MEC/Medical Staff meeting shall be:

- A. Call to order
- B. Acceptance of the minutes of the last regular and of all intervening special meetings.
- C. Report of the Executive Committee/Medical Staff
- D. Committee reports
- E. Discussion and recommendations for improvement of the professional work of the Hospital.
- F. Old business
- G. New business
- H. Report from Administration
- I. Adjournment

The agenda at special meetings shall be:

- A. Reading of the notice calling the meeting
- B. Transaction of business for which the meeting was called

C. Adjournment

All-important actions of the Executive Committee shall be included in the Executive Committee's report to the Medical Staff at any regular meeting or any special meeting called for the purpose of receiving the Executive Committee's report.

Section 4 - Provisions Common to Meetings of the Medical Staff

4.1 - Notice of Meetings

Notice of all meetings of the Medical Staff and regular meetings of committees shall be placed in the physicians' Hospital mailbox at least five days in advance of such meetings. Such posting shall be deemed to constitute actual notice to the persons concerned. The attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting.

4.2 - Attendance Requirements

- A. Each Active Staff appointee shall be required to attend at least fifty percent (50%) of all regular Medical Staff meetings and applicable regular department and committee meetings in each year, but is expected to attend all meetings.
- B. All members of the Active Medical Staff shall be required to attend at least fifty percent (50%) of each assigned meeting of the Medical Staff, department meetings, or committee meetings to which they are appointed.
- C. Attendance records shall be kept at all meetings. Excused absences shall not be counted as attendance.
- D. Failure to meet this requirement shall constitute automatic loss of staff privileges.
- E. Absences at four (4) consecutive meetings of the Medical Staff, department meetings or committee meetings, shall result in automatic withholding of privileges from the Active Medical Staff.
- F. Upon receipt of a notice from the Medical Staff Secretary-Treasurer of the violation of this rule, the physician may voluntarily relinquish his/her privileges by informing the Medical Staff Office within seventy-two (72) hours after receiving the notice.
- G. Should the physician fail to voluntarily relinquish his/her privileges the physician shall be notified by the Medical Staff Coordinator that his/her privileges have been withheld.
- H. While the privileges are withheld, the physician cannot admit any new patients under his/her name or in another physician's name. The physician, whose privileges are withheld, shall remain responsible for providing care for those patients who are presenting under his/her care either as the attending or consulting physician.
- I. Once privileges are withheld, the physician may reapply for admitting privileges in writing, to the Chief of Staff with a copy to the Hospital's CAO.
- J. Any Medical Staff appointee whose clinical work is scheduled for discussion at a regular department meeting shall be so notified and shall be expected to attend such meeting. If such individual is not otherwise required to attend the meeting, he/she shall be given advance written notice of the time and place of the meeting at which his/her attendance is expected.
- K. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall be so stated, shall be given by certified mail, return receipt requested, and his/her attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.
- L. Any member of the Medical Staff may be summoned to attend a staff or committee meeting upon written notification ten days in advance of the meeting at which his/her presence is required. The physician so notified may be excused from one meeting, but if so excused,

he/she must attend the following meeting. His/her failure to attend shall result in automatic loss of staff privileges.

- M. Persons appointed to as an Allied Health Provider of the Medical Staff may attend and participate clinical meetings of the Medical Staff but shall not have voting privileges nor shall this be considered as a condition of continued staff appointment.

4.3 - Quorum

The presence of one-half of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff, or its committees. Attendance via phone conference is regarded as being presence. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

4.4 - Voting

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

Section 5 – Credentials Committee

5.1 - Composition

The Credentials Committee shall consist of one member of the Active or Courtesy Medical Staff. The Medical Staff Coordinator and the Director of Quality & Compliance will serve as ex-officio members. The Chairman shall be appointed by the Chief of Staff. Service on this Committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere. The Chief of Staff shall appoint up to two additional members of the committee for terms of one year; if at any time the continued functions of the committee is threatened by the inability or unwillingness of any member or members to complete their duties.

5.2 - Duties

The duties of the Credentials Committee shall be:

- A. To review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges such credentials to be considered by the Committee shall include but not be limited to those identified in the Medical Staff Rules and Regulations.
- B. To make investigations of and interview such applicants as may be necessary.
- C. To make recommendations on the same to the Medical Staff/Executive Committee in accordance with Article XIII of these By-laws.

5.3 - Meetings, Reports and Recommendations

The Credentials Committee shall meet as often as necessary to accomplish its duties and shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the MEC.

5.4 - Special Committee Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, five (5) members of the Active/Courtesy Medical Staff, or upon request of the Board. The procedure for a special called meeting of the Medical Staff shall be by notification of the staff at least five days prior to the meeting. At any special meeting, only the business shall be transacted which is stated in the notice of calling the meeting.

5.5 - Minutes

Minutes of each meeting of each committee shall be prepared and shall include a record of the attendance of members and the recommendations made. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Executive Committee. Each committee and each department shall maintain a permanent file of the minutes of each of its meetings.

Section 6 – Bylaws Committee

6.1 - Composition

The Bylaws Committee shall consist of one member of the Active/Courtesy Medical Staff. The Medical Staff Coordinator and Director of Quality & Compliance will be ex-officio members of the committee. The Chairman of the committee shall be appointed by the Chief of Staff.

6.2 - Duties

The duties of the Bylaws Committee shall be:

- A. Review the Medical Staff Bylaws at least once every two years and to recommend any changes to assure compliance with local, state and federal laws, as well as the accrediting body's requirements;
- B. Propose amendments to the Bylaws for approval by the Executive Committee and Full Medical Staff as requested by either the Executive Committee or the Full Medical Staff.

6.3 - Meeting, Reports and Recommendations

The Bylaws Committee shall meet as necessary to fulfill its obligations and shall maintain a permanent record of findings, recommendations and actions, and shall make a report thereof to the Executive Committee.

Section 7 – Emergency & Trauma Committee

7.1 - Composition

The Emergency & Trauma Committee shall consist of one member of the Active or Courtesy Medical Staff. The Chairman of the Committee shall be appointed by the Chief of Staff. The Trauma Coordinator, CNO, Director of Quality & Compliance, ED Director, Laboratory Director, Radiology Director and a representative of EMS shall be ex-officio members of the Committee.

7.2 - Duties

The Emergency Room Committee shall:

- A. Review retrospectively all pertinent emergency room cases.
- B. Monitor the trend of practices in the emergency room
- C. Review cases which do not meet the predetermined criteria.
- D. Perform quality assurance functions in reference to emergency room cases.
- E. Establish criteria for monitoring purposes.
- F. Review all emergency room death cases.

7.3 - Meeting, Reports and Recommendations

The Emergency & Trauma Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions and shall make a report thereof, of each meeting to the Medical Staff/Executive Committee.

Section 8 – Multi Departmental Committee

8.1 - Composition

The Multi-Department Committee shall consist of one (1) member of the Active or Courtesy Medical Staff. The Chairman of the Committee shall be appointed by the Chief of Staff. The Director of Quality & Compliance, Director, CNO, and other departmental shall be ex-officio members of the committee. Other Deaconess leadership may be ask to serve on the committee as deemed necessary.

8.2 - Duties

- A. To review and make recommendations concerning the quality of medical records for clinical pertinence and timely completion.
- B. To claim all immunities and maintain confidentiality in its peer review activities.
- C. To assist in setting organization-wide Quality Improvement (QI) goals.
- D. To plan and implement QI activities.
- E. To identify opportunities for improvement.
- F. To charter cross-functional QI Teams.
- G. To work cooperatively with departments to define and monitor measurable quality indicators.
- H. To monitor QI processes.
- I. To allocate needed resources.
- J. To oversee the utilization review process for all acute patient care settings at Deaconess Union County Hospital and make recommendations relative to the appropriate utilization of hospital facilities and service.

8.3 - Meeting, Reports and Recommendations

The Multi Departmental Committee shall meet monthly. Hospital departments shall report on a quarterly schedule. A permanent record of its findings, proceedings and actions shall be maintained and shall make a report thereof after each meeting to the Medical Staff/Executive Committee.

Section 9 – Pharmacy & Therapeutics Committee

9.1 - Composition

The Pharmacy Committee shall consist of at least one member of the Active or Courtesy Medical Staff. The Chairman of the Committee shall be appointed by the Chief of Staff. In addition, the Hospital pharmacist, Director of Nursing, and the Case Management Director shall be ex-officio members of the committee. Along with other staff as requested by the chairman.

9.2 - Duties

The Pharmacy Committee shall:

- A. Have a plan and systematic process for the monitoring and evaluation of the quality and appropriateness of pharmaceutical patient care services and for resolving identified problems.
- B. Devise and keep current a standard drug formulary based on input from all Medical Staff committees.
- C. Approve new antibiotics for inclusion into the formulary.
- D. Approve all drugs to be included in the IV push list and direct IV list.
- E. Approve all policies involving medication for all departments included in handling medications.
- F. Review all adverse drug reaction reports.
- G. Review all incident reports involving medication.
- H. Review performance improvement policies and reports involving medications.

9.3 - Meeting, Reports and Recommendations

The Pharmacy Committee shall meet bimonthly, shall maintain a permanent record of findings, proceedings and actions, and shall make a report thereof after each meeting to the CAO.

Section 10 – Surgical Case Review Committee

10.1 - Composition

The Surgical Case Review Committee shall consist of one member of the Active or Courtesy Medical Staff. Anesthesia, Surgery supervisor and the Director of Quality & Compliance shall be ex-officio members of the committee.

10.2 - Duties

The Surgical Case Review Committee shall:

- A. Review, retrospectively, all surgical cases whether a specimen has been obtained or not.
- B. Monitor the trend of practice of surgery.
- C. Review cases which might or might not have met the predetermined criteria.
- D. Carry out performance improvement functions in reference to surgical operative cases.
- E. Review for quality and appropriateness all invasive procedures.

10.3 - Duties of Surgical Case Review Committee in Reference to Transfusions

- A. Monitor the indications for transfusion.
- B. Monitor the quality of blood and blood products.
- C. Educate the Medical Staff in the utilization of blood and blood products.
- D. Review all blood reactions.
- E. Cooperate with the blood bank director; blood bank supervisor; blood supplier.
- F. Establish general policies for blood transfusion administration, permits, and informed consents, as approved by the Medical Staff/Executive Committee.

- G. Carry out performance improvement in reference to blood utilization and transfusion reactions.

10.4 - Meeting, Reports and Recommendations

The Surgical Case Review Committee shall meet as needed and maintain a permanent record of its findings, proceedings, and actions, and submit a report from each meeting to the Medical Staff/Executive Committee. Surgical monitoring and quality assurance will be submitted to the Multi-Departmental Committee on a quarterly basis.

Section 11 – Peer Review Committee

11.1 - Composition

The Peer Review Committee shall consist of the Executive Committee of the Medical Staff.

11.2 - Duties

- A. It shall address concerns relating to any matter which may constitute “grounds for action” under Article VIII of these Bylaws.
- B. It shall review, as questions arise, and investigate all information regarding the behavior and clinical competence of persons currently appointed to the Medical Staff, and as a result of such review to make recommendations on the same in accordance with Article VI of these Bylaws.
- C. The Peer Review Committee shall make recommendations for every matter referred to it to the Executive Committee.

11.3 - Meeting, Reports and Recommendations

The Peer Review shall meet on an Ad Hoc basis to address matters which are disciplinary in nature.

Section 12 – Standing Medical Staff Committees

The MEC or the Medical Staff may, by resolution and upon approval of the Board and without amendment of the Bylaws, establish additional committees to perform one (1) or more Medical Staff functions. In the same manner the Executive Committee or the Medical Staff may, by resolution and upon approval by the Board, dissolve or rearrange committee structure, duties, or composition as needed to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which are not assigned to a standing or special committee shall be performed by the MEC.

Section 13 – Ad Hoc Committees

Ad hoc committees shall be created, and their members and Chairmen shall be appointed by the Chief of Staff. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the MEC.

Article XV – Rules and Regulations

The Medical Staff shall adopt rules and regulations which are separate from these Bylaws in order to facilitate the work of the medical staff and allied health care providers in the Hospital. The MEC, in cooperation with the CAO of the Hospital, is empowered to institute or change rules by majority vote, subject to approval of the Hospital governing board, and shall report same to the staff.

Article XVI – Amendments

- A. The Medical Staff Bylaws and Rules & Regulations shall be reviewed every two years;
- B. The Medical Staff Bylaws and Rules & Regulations will be reviewed to reflect the Hospital's current practices with respect to Medical Staff organization and function;
- C. All Medical Staff Policies will be reviewed at least every two years.
- D. All proposed amendments to these Bylaws may be initiated by either the Medical Staff or the MEC. The proposal shall be submitted by the Bylaws Committee in writing and read, if so desired, by either of the above bodies when the proposal is submitted. There shall be a lapse of thirty (30) days before the amendment is next considered, and this consideration shall be made by the Medical Staff. The amendment shall require a two-thirds (2/3) majority vote of those active medical members present and voting. The amendment(s) shall become effective when approved by the Governing Board.
- E. The MEC shall have the power to adopt such amendments to the Bylaws which are, in the Committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, due to punctuation, spelling or other errors of grammar or expression.
- F. Such amendments shall be effective immediately and shall be permanent, if not disapproved, by the Medical Staff or the Governing Board within sixty (60) days of adoption by the MEC. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the MEC. Immediately upon adoption, such amendments shall be posted on the Medical Staff bulletin board for fourteen (14) days.
- G. These Bylaws and Rules & Regulations shall not be amended unilaterally by either the Medical Staff or the Board.

Article XVII – Adoptions

These Bylaws of the Medical Staff, which constitute Part II of the Corporate Bylaws of Deaconess Union County Hospital are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and henceforth, all activities and actions of the Medical Staff and of each individual exercising clinical privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws. They shall therefore be incorporated in the Corporate Bylaws of the Deaconess Union County, Inc., d.b.a. Deaconess Union County Hospital, Morganfield, Kentucky.

Appendix B

Reference Websites

American Medical Association-

<http://www.ama-assn.org/ama/pub/category/13337.html>

American Osteopathic Association-

http://www.osteopathic.org/index.cfm?PageID=aoa_ethics

American College of Surgeons-

<http://www.facs.org/fellows-info/statements/stonprin.html>

American Dental Association-

<http://www.ada.org/prof/prac/law/code/index.asp>

Deaconess Code of Conduct, contained in the Medical Staff General Rules and Regulations