

BYLAWS  
OF THE  
MEDICAL STAFF

ST. LUKE'S METHODIST HOSPITAL  
CEDAR RAPIDS, IOWA

2012

DRAFT PROPOSAL

MEC REVIEW SCHEDULED FOR 6/26/12

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**DEFINITIONS**

"Allied Health Practitioner" or "AHP" - means an individual who is permitted by law to provide patient care services as a *dependent practitioner* under the direct supervision of other licensed professionals, or an independent practitioner who is not eligible for clinical privileges. Allied Health Practitioners are not members of the Medical Staff.

"Administration" - means personnel hired by the governing body to implement the directives of that body.

"Administrative Medical Director" - means Director of Medical Affairs, Chief Medical Officer or physician designated by Administration to function in this capacity.

"Admitting Privileges" - means the authority to admit the patient to the hospital for ongoing care, to twenty-three hour observation, or to the outpatient surgery areas for any procedure which could potentially result in admission to the hospital or which requires a general anesthetic.

"Adverse Action" - An adverse action shall include the following

- Denial of Medical Staff appointment or reappointment
- Denial or restriction of requested or existing clinical privileges including mandatory proctoring, consultation
- Suspension of clinical privileges or membership for greater than 30 days for reasons related to clinical competence or professional behavior
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"Bedded Patients" – means those patients that are classified as inpatients, observation, or extended recovery

"Board of Directors" or "Board" - means the Board of Directors of St. Luke's Methodist Hospital, Cedar Rapids, Iowa, which is the governing body of the hospital.

"CEO or his/her representative" - means the Chief Executive Officer or individual appointed by the Board to act in its behalf in the overall management of the hospital.

"Completed Application" or "Completed Reappointment Application" means that all information required by these bylaws, including verification of all required information and receipt of responsive inquiries and letters of recommendation have been received.

"Clinical Privileges" or "Privileges" - authority that is granted to render specific patient services without supervision, consistent with licensure, education, training and experience, and includes unrestricted access to those hospital resources which are necessary to effectively exercise privileges.

"Co-Admitting Privileges" - means the authority to admit the patient to the hospital for ongoing care, to twenty-three hour observation, or to the out-patient surgery areas for any procedure which could potentially result in admission to the hospital or which requires a general anesthetic, subject to designating a member of the Medical Staff holding admitting privileges to assume responsibility for medical evaluation, history and physical examination and overall responsibility for the patient's course of care in the hospital.

Eligible Voting Members – means Active staff members of the medical staff entitled to vote,

"Ex Officio" – **are committee members** without the right to vote or attend executive sessions of the committee. Ex officio members do not count towards a quorum needed for a committee to conduct business.

“In Good Standing” - means membership and/or privileges are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leaves of absence).

“Investigation” - means a process specifically initiated by the Medical Executive Committee to evaluate a concern or complaint with a medical staff member or individual holding clinical privileges, and does not include activity of the Medical Staff Wellness Committee.

Medical Executive Committee or “MEC” - means the executive committee of the medical staff

“Medical Staff” - means the Medical Staff of St. Luke's Methodist Hospital, the organization of credentialed physicians, podiatrists, and dentists who have been granted medical staff membership pursuant to the bylaws of the medical staff.

“Member” - means any practitioner who is a member of the medical staff.

“Physician” - means an appropriately licensed medical physician and/or osteopathic physician.

“Practitioner” - means any dentist, oral/maxillofacial surgeon, podiatrist, or MD/DO who is a member of the medical staff or an applicant for medical staff membership and/or privileges.

“President of the Medical Staff” - represents the interests of the medical staff and is the chief executive of the medical staff.

“Special Notice” – means a letter sent by U.S. mail, registered with return receipt requested.

“Secret ballot” - means a written ballot that is returned in a double envelope to protect the identity of the person voting.

**ARTICLE I**  
**Purposes**

It is the responsibility of the medical staff to:

1. Initiate and maintain rules and regulations for self-*governance* of the medical staff.
2. Recommend to the Board qualified practitioners to the medical staff and to establish procedures governing the periodic monitoring, evaluation and review of a medical staff member's performance in the hospital.
3. Provide health education for the public and to provide medical education opportunities for medical staff and hospital employees.
4. Provide a forum whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the Board and the CEO.

These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital, to which the Medical Staff members and the Hospital intend to be bound.

**ARTICLE II**  
**Membership**

**SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP**

Membership on the medical staff of St. Luke's Methodist Hospital will be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. No aspect of medical staff membership or particular clinical privileges will be denied on the basis of gender, sexual preference, race, age, creed, color or national origin.

**SECTION 2. QUALIFICATIONS FOR MEMBERSHIP**

- a. Applicants must provide documentation of background, current Iowa licensure, relevant training and/or experience, demonstrated competence, adherence to the ethics of their profession, good reputation, and ability to work with others sufficient to assure the medical staff and the Board that patients cared for by them in the hospital receive medical care at the professional level of quality required by the medical staff.
- b. No applicant will be granted or denied membership on the medical staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that the practitioner is duly licensed to practice medicine, podiatry, or dentistry in this or in any other state, or that the practitioner is a member of any professional organization, or that he/she had in the past or presently is a member of this medical staff or is employed by or under contract with this hospital. Applicants will not be granted or denied medical staff membership or privileges because of membership on this or any other medical staff or professional organization, lack of employment by the hospital, or because of legitimate business activities that compete with the hospital or other medical staff members. Medical staff membership is granted only to applicants qualified and credentialed according to these bylaws. Only those holding current

membership or temporary privileges granted according to these bylaws may provide medical, osteopathic, dental and podiatric care at the hospital.

- c. The applicant must be able to respond to his/her hospitalized patients or requests for services within a reasonable time period as defined by the relevant medical staff departments.
- d. Each member of the medical staff must attest to or provide documentation that he/she has no physical or mental limitations relevant to the clinical privileges which would impair his/her ability to render quality patient care, at the time of initial application, during the pendency of the practitioner's appointment, and upon each application for additional privileges and biennial reapplication for medical staff membership and clinical privileges.
- e. Proof of current malpractice liability insurance is required for membership in amounts jointly agreed upon by the Medical Executive Committee and the Board of Directors. This coverage must be provided by an insurer licensed or approved by the Iowa State Insurance Commission. Proof of current coverage must be provided on an annual basis according to the insurance date, in order to remain an active, refer and follow, or adjunct member of the medical staff.
- f. All members of the medical staff must agree to subject their performance to, and participate in, the hospital's quality/risk management programs as the same may from time to time be in effect in accordance with the requirements of the responsible quality improvement organization and other external regulatory agencies.

### SECTION 3. RESPONSIBILITIES OF MEMBERSHIP

Each member of the medical staff will:

- a. Exercise any clinical privileges granted at the professional level of quality in an economically efficient manner as established by the medical staff taking into account patients' needs, the available hospital facilities and resources, and utilization standards in effect at the hospital. Nothing in these bylaws will be construed to authorize the hospital to exercise any supervision or control over the practice of medicine. The practitioner will maintain the ultimate responsibility for providing professional services to patients that are medically necessary, appropriate, and otherwise consistent with medical staff standards.
- b. Abide by the medical staff bylaws and by other policies and rules of the medical staff.
- c. Discharge such staff, department, committee, and all other functions for which the practitioner is responsible by staff category assignment, appointment, election, or other operation of these bylaws.
- d. Prepare and complete in a timely fashion the medical and other required records for all patients admitted and/or cared for by the practitioner.
- e. Participate in medical staff peer review and other quality improvement activities.

- f. Abide by the ethical principles of the practitioner's profession.
- g. Provide written copy of renewed licensure documentation as requested by the Medical Staff Office.

#### SECTION 4. CONDITION AND DURATION OF APPOINTMENT

- a. Initial appointments and reappointments to the medical staff will be made by the Board and will be for a period of not more than two years. The Board will act on appointments, reappointments, or revocations of appointment and the delineation of setting-specific privileges only after receiving a recommendation from the medical staff as provided in these bylaws.

Any practitioner whose engagement by the hospital or by any other organization in any administrative capacity with related clinical responsibilities which require membership on the medical staff should, unless otherwise provided by agreement with the hospital, be entitled to the same procedural fairness accorded any other medical staff member when his/her medical staff privileges are terminated or otherwise adversely affected.

- b. Reappointments will be for a period of not more than two years.
- c. Every application for staff appointment will be signed by the applicant and will contain the applicant's specific acknowledgment of every medical staff member's obligations to provide continuous care and supervision of his/her patients, to abide by the bylaws, rules and regulations of the medical staff, and to accept committee assignments and carry out all the responsibilities associated therewith.
- d. All members of the medical staff, except honorary members, are required to pay staff dues in order to retain staff membership.

#### SECTION 5. MEMBERS' CONFLICTS OF INTERESTS

Officers, department chairs, section chiefs, medical staff representatives, and those medical staff members selected for committees represent the interests of the medical staff in improving patient care. To meet this obligation to the medical staff and to enable decision-making, every medical staff leader and candidate, and all medical staff members appointed to committees will disclose potential conflicts of interest to the relevant medical staff authority. Membership and privileges are not affected by any conflict of interest or the declaration of any potential conflict of interest. Exercise of certain medical staff obligations and prerogatives may be affected by these conflict of interest requirements.

- a. **Members Subject to Disclosure Requirement -** Prior to the date of election or appointment, members must disclose conflicts of interest if:
  - They are asked to serve as proctors or reviewers;
  - They are appointed to committees or to chair committees, including but not limited to hearing committees;
  - They are asked to allow themselves to be nominated or are nominated for any leadership position.

The information is shared only with those who need the information to make an informed decision: those with a vote in the election obtain disclosure from candidates; peer review committee members obtain information from other committee members and reviewers; medical staff leaders obtain information from those who may be appointed to serve in a peer review or other decision-making

capacity. Failure to disclose upon reasonable request will automatically disqualify the member from the position at issue; repeated refusal to disclose can be grounds for disqualification from the position in which the conflict exists.

b. Disclosing Financial Information

Members' financial interests are unrelated to qualifying for and maintaining medical staff membership and privileges. However, financial interests could be an issue when the member performs peer review functions, serves as a proctor/observer, acts in medical staff leadership positions or on committees. Prior to the date of election or appointment, those financial interests that may influence or appear to influence members in certain leadership or decision-making situations must be disclosed to the appropriate committee chair or medical staff leader in those circumstances in which the interests are or could be involved, include **but are not limited to**:

- Hospital contracts, employment, lease, ownership interest, joint venture, or other financial relationship with the hospital or hospital system or any management company operating the hospital
- Employment, partnership or other economic affiliation with individuals or entities involved in the subject matter of the review or other medical staff activity
- Grants, academic affiliation, research support
- Significant interest in hospital vendors, suppliers, manufacturers, or donors
- Competitive or collaborative relationships
- Economic competitors
- Any relationship that is affected by the outcome of a peer review, medical equipment selection or other decision.

c. Disclosing Personal Information –

Members' personal affiliations and relationships are unrelated to qualifying for and maintaining medical staff membership and privileges. Personal relationships interests could be an issue when the member serves as a peer reviewer, in medical staff leadership and on committees. Those personal relationships that may influence or appear to influence members in certain leadership or decision-making situations must be disclosed in those circumstances in which the interests are or could be involved, including;

- Employment, partnership or other economic affiliation
- Family relationship/Friendship
- Enmity or serious hostility

Because of the potential adverse ramification of overly broad dissemination, any personal or financial information disclosed is shared only as needed and used solely for the purpose of resolving conflicts of interest.

d. Failure to disclose the conflicts of interest may invoke corrective action and fair hearing process.

e. Dealing with actual conflicts of interest - In the presence of a conflict of interest, the affected committee or decision making body will require the conflicted practitioner to do one or more of the following:

- i. Disclose actual or potential conflicts with proposed transactions or arrangements with the hospital or affiliated organizations
- ii. Vacate any meeting, if requested by the committee, where the committee discussion or actions relate to the matter giving rise to the reported conflict of interest.

- iii. Require the affected practitioner to refrain from voting on any matters giving rise to the potential conflict of interest unless permitted by a majority vote of those other members present where a quorum is present as defined by these bylaws.
- iv. Recuse themselves from any leadership position that requires making decisions or taking actions on behalf of the medical staff, department, or other decision making body where a conflict of interest is present that may influence their ability to make an unbiased decision in their leadership capacity.
- v. Disclose any payments received for acting in a leadership position, or the receipt of any financial gain from a transaction or financial arrangement with the hospital. Any affected member will not be present for discussions regarding the potential conflicting transaction.
- vi. Where the medical staff, committees, or decision making bodies discuss conflicts of interest, a permanent record of the proceedings will be retained in the MSO for 5 years.

### **ARTICLE III CATEGORY OF PRACTITIONERS**

The medical staff will be organized into active, adjunct, refer and follow, and honorary categories.

#### **SECTION 1. THE ACTIVE MEDICAL STAFF**

- a. The active staff will consist of practitioners, each of whom:
  - i. Meets the basic membership qualifications set forth in these bylaws and
  - ii. Regularly admits patients to, or is otherwise regularly involved in the care of patients in the hospital.
- b. The prerogatives of the active staff members will be:
  - i. To exercise such clinical privileges as are granted to the practitioner pursuant to these bylaws
  - ii. To vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which the practitioner is a member
  - iii. To hold office in the staff organization and in the department and committees of which the practitioner is a member
  - iv. To serve as members of the diagnostic reading panels, if granted specific privileges to do so under these bylaws.
  - v. To supervise allied health professionals if granted specific supervising privileges under these bylaws.
- c. Each member of the active staff will:
  - i. Meet the basic responsibilities set forth in these bylaws

- ii. Retain responsibility within the practitioner's area of professional competence for the continuous care and supervision of each patient in the hospital for whom the practitioner is providing services, or arrange a suitable alternative for such care and supervision;
- iii. Actively participate in performance improvement, utilization review, and other evaluation and monitoring activities required by these bylaws and consultation assignments as determined by the appropriate medical staff department policies;

## SECTION 2. THE ADJUNCT MEDICAL STAFF

- a. The adjunct staff will consist of practitioners, each of whom:
  - i. Is not otherwise an active or refer and follow member of the staff, and meets the general qualifications of medical staff membership established by these bylaws.
  - ii. Possess adequate clinical and professional expertise.
- b. The prerogatives of the adjunct staff will be:
  - i. To consult as reasonably requested by other members, exercising only such privileges as are specifically granted to each member pursuant to these bylaws. Adjunct staff may not hold admitting or co-admitting privileges or be solely responsible for managing a patient;
  - ii. To attend meetings of the staff and any staff or hospital education programs, but do not have the right to hold medical staff leadership positions or to vote on medical staff matters.
  - iii. To serve on committees and reading panels, as appointed.
  - iv. To pay medical staff membership dues.
  - v. To order routine outpatient diagnostic services and treatments including rehabilitation services and respiratory services as permitted under these bylaws.
  - vi. To apply for active medical staff membership adjunct staff requesting advancement to the active medical staff must apply for membership on the active staff as through an initial application to the medical staff.<sup>1</sup> Adjunct staff membership does not create any obligation to grant active medical staff status or membership to an applicant, or assume eligibility for admitting or co-admitting privileges.

## SECTION 3. REFER AND FOLLOW MEDICAL STAFF

The refer and follow staff consists of those staff members who do not have admitting privileges but refer their patients for admission, and wish to have information about their patient's care. There are no limitations to the number of contacts allowed to refer and follow staff, and they may apply for a different category of Medical Staff membership at any time.

- a. The prerogatives of the Refer and Follow Staff will be:

- Refer patients to an active staff member, with admitting privileges, for admission
- Visit and follow his/her patient while in the hospital
- Do informational or historical charting
- Unrestricted access to the medical record both remotely and at the hospital
- Directly communicate with the admitting physician or other consultants
- Attend and vote at meetings of the General Staff and of the Department and committees of which he/she is a member
- Serve on committees and reading panels, of the hospital and medical staff
- Pay dues as established by the Medical Staff
- To order routine outpatient diagnostic services and treatments including, but not limited to rehabilitation services and respiratory services as permitted under these bylaws.
- To apply for active membership status as permitted by these bylaws.

b. Limitations of the Refer and Follow Staff. A Refer and Follow Staff member may NOT:

- Write orders on bedded patients.
- Perform formal clinical examinations on any patient in the hospital.
- Serve in a medical staff leadership position or serve as chairman of any medical staff committee
- Provide emergency room coverage

#### SECTION 4. THE HONORARY MEDICAL STAFF

- a. The honorary staff will consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital.
- b. Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend staff and department meetings and any staff or hospital education meetings.
- c. Honorary staff members may not vote, but may serve on medical staff committees without vote.

#### SECTION 5. CONTRACT AND EMPLOYED MEMBERS OF THE MEDICAL STAFF

- a. Contracted physicians, and those members with an exclusive, part-time, panel or other basis for employment, and those who provide clinical services to patients or provide back-up call or other coverage:
  - i. must meet all qualifications set forth in and otherwise comply with the medical staff bylaws and
  - ii. are subject to the same peer review, credentialing, hearing and appeal processes established in these bylaws.
- b. Contracted members may qualify for election to medical staff leadership and appointment to committees, but must disclose their contractual relationships as potential conflicts of interest.

- c. Contracted members will not be subject to termination of contract or other penalties solely as a result of carrying out leadership and other medical staff responsibilities in good faith.

**ARTICLE IV**  
**Procedure for Appointment and Reappointment**

**SECTION 1. APPLICANT FOR INITIAL APPOINTMENT**

- a. All applications for appointment to the medical staff will be in writing, signed by the applicant, and submitted to the Medical Staff Office on a form jointly approved by the Medical Executive Committee as well as the Board. The application requires detailed information concerning the applicant's professional qualifications. This includes the name of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence, and ethical character. This application will include information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed at any other hospital or institution, or whether his/her license to practice any profession in any jurisdiction has ever been voluntarily/involuntarily suspended or terminated. The application will require information about all previous adverse actions against him/her, including judgments and settlements in malpractice suits, and pending challenges to his/her ability to practice competently. The applicant will provide the status of his/her drug enforcement administration number and report limitations or restrictions on his/her ability to practice that have been imposed by other licensing regulatory or credentialing bodies. This includes reporting any voluntarily/involuntarily loss or change in medical staff membership or privileges elsewhere, or whether the applicant is currently, or has ever been excluded from Medicare, Medicaid, or any other federal healthcare program.
- b. The applicant has the burden of producing adequate information for proper evaluation of his/her competence, character, ethics, current health status, data from professional practice review by an organization(s) that currently privileges the applicant (if available) and other qualifications and for resolving any doubts about such qualifications. Any intentional misrepresentation, material misstatement or omission from the application will be cause for rejection of the application without the right of appeal. If additional information is required of the applicant to establish that he/she meets the qualifications described in these bylaws, the Administrative Medical Director/or Designee will request it in writing by special notice. If the AMD is unavailable, the POMS will, by special notice request additional information from the applicant. The application will not be processed by the MSO until all requested present and current information is received.
- c. If the applicant, subsequent to the date upon which the application was completed and during the time the application is pending, becomes aware of information that could be in any way relevant to this application, the applicant will provide such information in writing within five business days to the medical staff office in order to supplement or amend his/her application.
- d. The complete application will be submitted to the Medical Staff Office. The Medical Staff Office will maintain a file of all applications including date of receipt and disposition. The Medical Staff Office will determine whether the application is complete before forwarding it to the department chairman and must advise the applicant that the application will not be considered until it is complete, including the required letters of reference. After collecting the references and other materials deemed pertinent, the Medical Staff Office will transmit the application and supporting materials to the department chairman for evaluation. The department chairman will review the application and make a

recommendation to the Credentials Committee. The recommendation may be for approval as submitted, approval with modification or denial. Any recommendation other than for approval will be accompanied by the reason for the adverse recommendation.

- e. By applying for appointment to the medical staff, each applicant thereby agrees to appear for interviews in regard to the application; authorizes the hospital to consult with members of the medical staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her professional qualifications, competence, character, ethical qualifications and current health status. The applicant consents to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges the applicant requests. The applicant releases from any liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials, and releases from any liability those individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointments and clinical privileges including otherwise privileged or confidential information.
- f. The application form will include a statement that the applicant has received and read the bylaws, rules and regulations of the medical staff and that the applicant agrees to be bound by the terms thereof whether or not the applicant is granted membership and/or clinical privileges.

## **SECTION 2. APPOINTMENT PROCESS**

- a. The appointment and credentialing process requires the Credentials Committee to verify from the primary source or from a credentials verification organization as applicable, the following information:
  - 1) The practitioner's current licensure at the time of granting privileges, renewal of privileges and expiration of privileges;
  - 2) Evidence of physical ability to perform the requested privilege
  - 3) Data, if available, from professional practice review by an organization(s) that currently privileges the applicant;
  - 4) Written peer and/or faculty recommendation
  - 5) Authenticated, written record of the practitioner's specific relevant training; and
  - 6) Documented evidence of a practitioner's current competency
- b. Before granting appointment and setting-specific clinical privileges, the organized medical staff must evaluate the following:
  - 1) Challenges to any licensure or registration
  - 2) Voluntary and involuntary relinquishment of any license or registration
  - 3) Voluntary and involuntary termination of medical staff membership
  - 4) Voluntary and involuntary limitation, reduction, or loss of clinical privileges
  - 5) Information concerning any unexpected, or unexplained pattern of professional liability actions resulting in final judgment and/or settlement against the applicant
  - 6) Documentation as to the applicant's current health status
  - 7) Relevant practitioner-specific data as compared to aggregate data, when available, and
  - 8) Performance measurement data including morbidity and mortality data, when available
- c. The Credentials Committee will determine through information given by the practitioner, National Data Bank query response, if available, and from other sources available to the committee, including an appraisal from the clinical department chairman in which privileges are sought, whether the practitioner meets all of the qualifications for the category of staff membership and the setting-specific

clinical privileges requested by him/her. Recommendations regarding staff membership and privileges made by the Credentials Committee requires a two-thirds majority vote of all of the members of that committee present and voting at a meeting where a quorum is present. Every department in which the practitioner seeks clinical privileges will provide the Credentials Committee with specific written recommendations for delineating the practitioner's setting-specific clinical privileges, and these recommendations will be made a part of the report. Within ninety (90 days) after receipt of the completed application for membership, the Credentials Committee will make a written report to the Medical Executive Committee, including its recommendations that the practitioner be appointed to the medical staff, or rejected for medical staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend conditions relating to such setting-specific clinical privileges. Any recommendation other than for approval should be accompanied by the reason for the adverse recommendation.

- d. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Medical Executive Committee will determine whether to recommend to the Board that the practitioner be appointed to the medical staff, that the applicant be rejected for medical staff membership, or that the applicant's application be deferred for further consideration. All recommendations to appoint must also specifically recommend the setting-specific clinical privileges to be granted, which may be qualified by restrictions or specific conditions affecting the granting of clinical privileges.
- e. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for appointment with specified setting-specific clinical privileges, or for rejection of staff membership.
- f. When the recommendation of the Medical Executive Committee is favorable to the practitioner, the Administrative Medical Director/designee will promptly forward it, together with all supporting documentation to designated representatives of the Board. These representatives, acting on behalf of the Board, and as direct agents of the Board, are authorized, with the concurrence of the POMS and relevant department chair, when necessary, to render expedited appointments and clinical privileges. All actions by the designated Board representatives will be ratified by the full governing body at its first subsequent meeting.
- g. When the recommendation of the Medical Executive Committee is adverse to the practitioner, either in respect to appointment or clinical privileges, the hearing procedures as provided in these bylaws are followed. The governing body will be advised of all adverse recommendations.
- h. At its next regular meeting, after receipt of a favorable recommendation, the Board will act on the matter. The Board's adoption of the favorable recommendation is the final action on the application. If the Board decision is adverse to the practitioner either with ~~in~~ respect to appointment or clinical privileges, the hearing procedures as provided in these bylaws are followed.
- i. At its next regular meeting, after all of the fair hearing procedures under these bylaws have been exhausted or waived, the Board, or its duly authorized committee, will act on the matter. The Board's decision will be conclusive, except that the Board may defer final determination by referring the matter back to the hearing committee or MEC if applicable, for further consideration as permitted under these bylaws. At its next regular meeting after receipt of such subsequent recommendation and new evidence of the matter, if any, the Board will make a decision either to appoint the practitioner to the staff, or to reject him/her for staff membership.

- j. When the Board's decision is final, it will send written notice of such decision through the President of the Medical Staff and by certified mail, return receipt requested, to the practitioner.

### SECTION 3. REAPPOINTMENT PROCESS

- a. On or before four months prior to the date of expiration of a medical staff member's appointment, the Medical Staff Office will notify the practitioner of the date of expiration and send an application for reappointment to be completed. At least ninety (90) days prior to the expiration date, the member will furnish, in writing, a completed application for reappointment including:
  - i. Complete information and all documents necessary to make his/her file current as listed in the notification, including current license and DEA and state controlled substances registration, professional liability insurance coverage and experience, other institutional affiliations and membership status, board certification status, disciplinary actions pending/completed, health status changes;
  - ii. Specific request for additions to or deletions from the clinical privileges presently held, with any basis for changes; and
  - iii. Requests for changes in staff category.

The staff member must sign the reappointment application and in so doing accepts the same conditions as stated in these bylaws in connection with the initial application.

If the applicant, subsequent to the date upon which the application was completed and during the time the application is pending, becomes aware of information that would be in any way relevant to this application, he or she will provide such information to the Medical Staff Office in writing within five (5) working days in order to supplement or amend his/her application.

- b. Each applicant must complete and return the application for reappointment to the Medical Staff Office within thirty (30) days. If not received in time, the Medical Staff Office will send the practitioner a special notice granting the practitioner a seven-day grace period in which to submit the completed application or to request an extension. Failure, without good cause to submit a reappointment application or to request an extension prior to or within the grace period is deemed a voluntary resignation from the staff and results in an automatic administrative revocation of membership and privileges on the expiration date of the practitioner's current membership term. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in the fair hearing plan for the sole purpose of determining the issue of whether there is a good cause explanation for failure to timely submit an application under this paragraph.
- c. The Medical Staff Office verifies the information provided on the reappointment application, and notifies the staff member of any information inadequacies or verification problems. This notification must be by special notice, and must indicate the nature of the additional information the staff member is to provide and the deadline for the required response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether good cause existed for the failure to comply with the reapplication process.

- d. If the staff member's level of clinical activity at this hospital is not sufficient to permit the applicable medical staff clinical department, credentials committee, MEC and Board authorities to make an informed judgment as to the practitioner's competence in exercising the clinical privileges requested, the staff member will have the burden of providing evidence of satisfactory clinical performance.
- e. The Medical Staff Office collects for each staff member's credentials file all relevant information regarding the individual's professional performance and conduct as it pertains to the quality of patient care in the hospital. Such information, which together with the information obtained above, will form the basis for recommendations and actions which will include, without limitation:
  - i. Patterns of care and utilization as demonstrated in the findings of quality review (including medication use, blood and blood component use, operative and other procedure(s), risk management and utilization management activities,
  - ii. Pending or prior sanctions imposed by other health care facilities or government entities, including current or prior exclusion from Medicare, Medicaid, or any state or federal health program.
  - iii. Health status,
  - iv. Timely and accurate completion and preparation of medical records,
  - v. Professionalism in working with other practitioners and hospital personnel as it affects patient care,
  - vi. Ethical behavior, demonstrated clinical competence and clinical judgment in the treatment of patients for privileges currently exercised or requested,
  - vii. Compliance with all applicable bylaws, policies, rules and procedures of the medical staff,
  - viii. Any other pertinent, reliable information regarding clinical ability and professional ethics that may be relevant to the staff member's category and privileges at this hospital including the staff member's activities at other hospitals and medical practice outside the hospital,
  - ix. Satisfying state licensing requirements for continuing medical education
- f. The Medical Staff Office transmits the reappointment application and the supporting information and the staff member's credentials file, or relevant portions thereof, with the other required information required by these bylaws to the chairman of the department in which the staff member is requesting privileges.
- g. The appropriate clinical department chair in which the staff member requests or has exercised privileges will review the reappointment application and its supporting information. If a department chairman requires further information, he/she will notify, through the Medical Staff Office, the staff member in writing or electronic means of the additional information required. The notice *will* include a request for the further information required and the time frame for a response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether good cause existed for the failure to comply with the reapplication process.

- h. Each department chairman forwards to the Credentials Committee a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category and clinical privileges.
- i. The Credentials Committee will review and evaluate the reappointment application and its supporting information, reports and other relevant information available to it. If the Credentials Committee requires further information, it will notify, through the Medical Staff Office, the staff member by special notice of the information required. The notice will include a request for the specific information required and the time frame for response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether good cause existed for the failure to comply with the reapplication process.
- j. The Credentials Committee will prepare a written report with recommendations for, and special limitations on, reappointment or non-reappointment and staff category and requested clinical privileges. The Credentials Committee's report is transmitted with the chairman's report and supporting documentation as required to the Medical Executive Committee.
- k. Thereafter, the procedure provided in these bylaws relating to recommendations on applications for initial appointment will be followed.

#### SECTION 4 – MEMBER ACCESS TO CREDENTIALS FILES –

All information relevant to the credentialing of a member shall be included in his/her credentials file.

##### a. Limited Access to medical staff credentials files -

Access to medical staff credentials files is strictly limited only to those medical staff leaders and administrative personnel carrying out peer review activities authorized by these bylaws, and only as needed to fulfill their legitimate duties.

##### b. Medical staff members access to personal credentials files -

Medical staff members are granted access to all information in their own credentials files upon written request, except for letters of reference. Records are reviewed in the medical staff office, at a time convenient to the member and the medical staff office director or designee, in whose presence the member's review will take place. The member may receive a copy of only those documents provided by or addressed personally to the member. In the event of an action or proposed action against a member, applicant, or holder of clinical privileges, access to that member's credentials file is governed by the hearing procedures established in the medical staff bylaws.

##### c. Making corrections to the credentials file - A member may forward a request in writing to the MEC that his/her credentials file be corrected, or additional information be added to the file. Information supporting the request should be included. The member is notified promptly, in writing, of the decision of the medical executive committee to amend, modify or leave the credentials file unchanged.

- d. Restrictions on information in the Credentials Files – Any person may provide information to the medical staff regarding the professional conduct or practice of a medical staff member. The chairman of the relevant clinical department and the POMS or designees together will determine whether any such report is reliable, and should be included within a provider credentials file. The affected practitioner will be notified in writing if a reliable complaint has been received to allow the member an opportunity to respond to any allegation of practice or conduct falling below the professional standards established by these bylaws.

## SECTION 5. LEAVE STATUS

To obtain a leave of absence, lasting greater than 6 months, from the medical staff, a member must submit a written request for leave to the Medical Staff Office, which will send a copy of the request to the applicant's clinical department chairperson(s) and to the Medical Executive Committee. If the leave of absence is unplanned, notification should be sent as soon as possible to the Medical Staff Office. The leave request may not be for a period of more than two years or the pending period of membership, whichever expires first. The request should state clearly the reason for the leave of absence. Upon receipt of the leave of absence request, the Medical Staff Office will notify the member of the requirement to notify the Medical Staff Office of their request to return to active practice.

At least 30 days in advance, the affected member must submit a written request for reinstatement of clinical privileges and/or medical staff membership to the Medical Staff Office, which will forward the request to the relevant department chairperson(s) and the MEC for review. The request will include a brief explanation or general description of the member's activities during the leave period. The appropriate clinical department chairperson(s) will determine whether the member needs re-evaluation to renew some or all privileges, and will make a recommendation to Credentials Committee which will then forward it to the MEC.

A medical staff member returning from a medical leave of absence may be required to provide the following information, including but not limited to:

- Current documentation of health status
- A current physical examination may be required to affirm that the affected practitioner is physically capable of providing patient care at an expected level of quality required by the medical staff.

After consultation with the department chairperson(s) and the Credentials Committee, the MEC will make a recommendation to the hospital board concerning the reinstatement of the member's privileges and membership. If the MEC recommends denying reinstatement, or if the hospital board rejects an MEC recommendation for reinstatement, the member will be entitled to hearing and appeal rights as provided in these bylaws.

Failure without good cause to submit the required written request for reinstatement of privileges/membership is deemed a voluntary resignation from the medical staff; however, the member is entitled to a hearing under these bylaws for the sole purpose of determining whether good cause existed for failure to submit a request for reinstatement as required under these bylaws.

**ARTICLE V**  
**Clinical Privileges**

**SECTION 1. NATURE OF CLINICAL PRIVILEGES**

Core Principle - The decision to grant clinical privileges under these bylaws is based primarily, but not solely on the concept of demonstrated competency for each requested clinical task, activity or privileges. Additional factors may be considered by the clinical department, the Credentials Committee, and/or the Medical Executive Committee in deciding whether to grant, deny or restrict clinical privileges.

The renewal or revision of medical staff membership or clinical privileges is based on a current reappraisal of the medical staff member including the completion of a formal focused professional practice evaluation (FPPE) prior to renewal of initial staff membership or new clinical privileges. For new clinical privileges, a focused review of those privileges must be completed within 18 months of granting these privileges. In evaluating a request for clinical privileges, the following principles apply:

- a. No physician or non-physician practitioner is entitled to membership or clinical privileges based solely on state licensure, certification, a contract or employment relationship with the hospital, or having completed a formal training curriculum in any health related field.
- b. No practitioner is granted privileges solely on the basis of having satisfied existing medical staff criteria for setting specific clinical, or proposed clinical privileges.
- c. No practitioner is entitled to clinical privileges where granting these privileges cannot be supported by the facility because of inadequate physical resources, or inability to fully support these kinds of clinical activities.
- d. Even for well-qualified applicants, the Credentials Committee must consider whether granting clinical privileges may substantially limit or impair the ability of existing clinical privilege holders in maintaining the minimum number of procedures or clinical activities required to maintain clinical competence for each task or activity. In this setting, the relevant clinical department, Credentials Committee, and/or the Medical Executive Committee may, in good faith, reject a request for clinical privileges from competent, well-trained individuals. In this instance the failure to grant privileges is not reportable to the NPDB.
- e. Granting clinical privileges must also consider existing standards that affect the ability of a practitioner to satisfy their department based obligation to provide after-hours services, and to meet existing medical staff or departmental standards for timely reporting of test results.
- f. Clinical privileges may not be granted or denied on the basis of a practitioner's affiliation with other health care entities, competing health facilities, or to directly or indirectly reward or punish practitioners for these relationships or affiliations.
- g. Practitioners are not required to apply for, or hold all clinical privileges for which they are qualified.

## SECTION 2. BASIS FOR PRIVILEGES DETERMINATION

In all cases, the applicant has the burden of establishing his/her qualifications and competency for each requested clinical privilege. The criteria for granting clinical privileges will be fairly and consistently applied to all applicants. The recommendation to grant or deny privileges is based upon:

- a. Primary Source Verification of applicant information, including verification of:
  - i. Current licensure
  - ii. Medical education
  - iii. Medical training
  - iv. Past and current clinical experience
  - v. Demonstrated competence to meet the credentialing and privileging standards consistent with privileging standards establish by the Centers for Medicare and Medicaid Services Conditions of Participation.
  - vi. Peer and faculty references
  - vii. Health status and physical ability to perform requested privileges
  - viii. Individual appraisal by the service in which privileges are sought
- b. Peer Recommendations – includes a written evaluation of the practitioner’s:
  - i. Medical/clinical knowledge
  - ii. Technical and clinical skills
  - iii. Clinical judgment
  - iv. Interpersonal skills
  - v. Communication
  - vi. Professionalism
- c. Voluntary or involuntary changes in licensure, medical staff membership and/or clinical privileges
- d. An excessive or unusual pattern of professional liability actions resulting in a final judgment against the applicant
- e. Relevant practitioner-specific data, including morbidity and mortality data when available.
- f. Criminal background check

## SECTION 3. EXERCISE OF PRIVILEGES

- a. Each medical staff member is entitled to exercise only those clinical privileges specifically recommended by the medical staff and granted to the practitioner by the Board, consistent with these bylaws.
- b. Prior to granting new or additional privileges not currently listed on a practitioner’s delineation of privilege form, the department chairman and appropriate hospital personnel will determine whether the resources necessary to support the requested privilege are currently available or are available within a specified time frame.
- c. Request for delineation of privileges forms are reviewed by the relevant section(s) and department(s), and when changes are recommended, forwarded to the Medical Executive Committee, so that the forms and privileging by the department do not conflict with the current criteria or these bylaws.

## SECTION 4. ADMITTING PRIVILEGES

Core Principle - Admitting Privileges may be granted only to practitioners who are granted the authority to assume overall medical responsibility for care of patients admitted to a hospital bed. This includes performing the medical evaluation, including the history and physical examination, supervising all other practitioners providing services and directing the patient's overall course of care in the hospital, and completing the patient chart upon discharge. Admitting privileges are not restricted to employees or contractors of the hospital, or to any medical specialty.

## SECTION 5. CO-ADMITTING PRIVILEGES

Co-admitting Privileges – entitle the practitioner to admit a patient to the hospital for treatment within the practitioner's area of licensure, subject to designating a member of the medical staff holding admitting, and history and physical privileges to assume responsibility for the medical evaluation, history and physical examination, and overall medical responsibility for the patient's course of hospital care. Practitioners with co-admitting privileges must designate a *named* member of the active medical staff at the time of admission who assumes responsibility for the evaluation and care of the affected patient. Patients of allied health professionals must be admitted by a physician member of the *active* medical staff who will be responsible for the care of all medical issues requiring treatment during the hospitalization.

## SECTION 6. TEMPORARY PRIVILEGES

- a. Upon receipt of a completed application from an appropriately licensed practitioner for medical staff membership and upon receipt of a written request for temporary privileges, the Chief Executive Officer or designee with the written concurrence of the relevant department chair and president of the medical staff may grant temporary privileges for a specified number of days, not to exceed the pendency of the application or 120 days, whichever is shorter, after receipt and verification of:
  - Current licensures
  - Relevant training or experience
  - Current competence
  - Demonstrated ability to perform the clinical privileges requested
  - Other criteria required by these medical staff bylaws
  - Query and evaluation of National Practitioner Data Bank information
  - Absence of current or previously successful challenge to licensure or registration,
  - Absence of involuntary termination of medical staff membership at any hospital or other entity,
  - Absence of any involuntary limitation, reduction, denial or loss of clinical privileges, and
  - Proof of required malpractice liability coverage.
- b. Special Care Need - Upon receipt of a request for specific temporary privileges, an appropriately licensed practitioner of documented competence, who is not an applicant for membership, may be granted temporary privileges for the care of one or more specific patients to fulfill an important patient care need. Such privileges will be exercised in accordance with the conditions specified in the granting of temporary privileges to not exceed 60 days in a twelve-month period.
- c. Locum Tenens  
Upon receipt of a request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is serving as a locum tenens for a named member of the medical staff and therefore serving an important patient need may, without applying for membership on the staff be granted temporary privileges for up to 60 days with subsequent renewals not to exceed the need for the locum tenens services. Such privileges will be limited to treatment of the patients of the practitioner

for whom he/she is serving as locum tenens and will be exercised in accordance with the conditions specified in the granting of temporary privileges.

The CEO or designee, and with the written concurrence of both the department chairperson and the president of the medical staff may grant locums tenens privileges to a physician requesting the right to provide medical coverage for a named member of the active medical staff.

The provider requesting locum tenens privileges must submit a full application for locum tenens assignments to the Medical Staff Office. The applicant must provide the following information to the Medical Staff Office:

- Current licensures
- Relevant training or experience
- Current competence
- Demonstrated ability to perform the clinical privileges requested
- Other criteria required by these medical staff bylaws
- Query and evaluation of National Practitioner Data Bank information
- Absence of current or previously successful challenge to licensure or registration,
- Absence of involuntary termination of medical staff membership at any hospital or other entity,
- Absence of any involuntary limitation, reduction, denial or loss of clinical privileges, and
- Proof of required malpractice liability coverage.
- The named member of the medical staff for which locums tenens coverage is provided

If the Medical Staff Office has verified all required information, the locum tenens provider may be permitted to provide long term coverage to inpatients for a period not to exceed 60 days, without applying for medical staff membership.

- d. Special requirements of supervision and reporting may be imposed by the appropriate department for the provider granted temporary privileges or locum tenens. In exercising such privileges, the applicant will act under the supervision of the chairman of the department to which he/she is assigned and in accordance with the conditions specified in the granting of temporary privileges. Temporary privileges are immediately terminated if either the clinical department chair or president of the medical staff, in consultation with the Administrative Medical Director/designee, identifies any failure by the practitioner to comply with such special conditions. If reportable, termination of /or action against temporary privileges gives rise to hearing rights under these bylaws.
- e. All persons requesting or receiving temporary privileges are bound by the Bylaws and Rules and Regulations of the Medical Staff. If temporary privileges are terminated for a reportable reason, hearing and appeal rights apply.

## SECTION 7. EMERGENCY PRIVILEGES

In an emergency, any member of the medical staff with clinical privileges, to the degree permitted by his/her license and regardless of privileges, service or staff status is permitted and entitled to use every facility of the hospital and to do everything possible within the scope of his/her license to treat an emergent medical condition within the hospital. For the purpose of this section, an emergency is defined as a condition in which immediate treatment is necessary to prevent serious permanent harm to a patient, to preserve the life of a patient, or to prevent serious deterioration or aggravation of a patient's condition. When a member credentialed and privileged under these bylaws to provide the emergency treatment becomes available, and if

it is otherwise feasible to do so, the member exercising emergency privileges will promptly yield care of the patient to practitioners credentialed and privileged under these bylaws. The member exercising emergency privileges may request the privileges necessary to continue treating the patient. In the event that privileges are denied or the practitioner does not desire to request privileges, the patient will be assigned to an appropriate member of the medical staff.

## SECTION 8 DISASTER PRIVILEGES

Disaster privileges may be granted to non-members of the medical staff when the hospital has activated its emergency management plan and is unable to handle the immediate patient needs. The Chief Executive Officer or the President of the Medical Staff or their designee(s) may grant such privileges based upon information available which may be reasonably relied upon as evidence of personal identification and qualification. At a minimum the individual must have a current photo I.D. issued by a state or federal agency and at least one of the following:

- Current valid medical license;
  - Primary source verification of the license;
  - Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner;
  - Identification indicating that the individual is a member of a DISASTER MEDICAL ASSISTANT TEAM (DMAT), or Medical Reserve Corps (MRC), or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
  - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances. Such authority has been granted by a federal, state, or municipal entity.
  - Verification that the individual has been granted authority by an appropriate state or federal entity to render emergency patient care during a disaster. Any individual who receives disaster privileges under the hospital's emergency management plan must wear at all times a means of identification and will act under the supervision of the chairperson of the department to which he/she is assigned.
- a. Verification of the credentials of a non-member of the medical staff functioning under the emergency management plan begins when the emergency situation is stabilized and completed within 72 hours from the time the practitioner presented to the organization. The process of verification is the same as that for granting temporary privileges as described in the temporary privileges section of the bylaws.
- b. All disaster privileges will immediately terminate once the emergency condition is no longer present.

## SECTION 9. HISTORY AND PHYSICALS PRIVILEGES

- a. History and physical privileges are granted only to those members approved to conduct or update history and physical examinations. History and physical privileges must be carried out consistent with the requirements of these bylaws.
- b. A History and physical examination must be performed prior to surgery or a procedure requiring general anesthesia services so that each patient is provided a history and physical examination within 30 days before admission (or registration, if an outpatient procedure) or within 24 hours after admission.
- c. When the medical history and physical examination are completed within 30 days before admission, an updated examination of the patient, including any changes in the patient's condition must be

completed and documented within 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services.

- d. Practitioners eligible for History and Physical privileges include:
- Physicians – Physician medical staff members or physician applicants for temporary privileges may be granted privileges to conduct and update histories and physicals if they apply and are approved for such privileges through the privileging and credentialing processes.
  - Podiatrists – Podiatrists co-admit with an active staff physician who is responsible for the podiatric patient’s inpatient care and for treating medical problems or conditions that may exist at the time of admission including performing admission history and physical or medical problems that arise during hospitalization that is beyond the scope of the podiatrist’s license. The admitting physician determines the risk and effect of a proposed podiatric procedure on the total health status of the patient.
  - Dentists/Oro-maxillofacial Surgeons – Dentists/Oro-maxillofacial Surgeons co-admit with an active staff physician who is responsible for the dental patient’s inpatient care and for treating medical problems or conditions that may exist at the time of admission including performing admission history and physical or medical problems that may arise during hospitalization that is beyond the scope of the dentist’s license. The admitting physician determines the risk and effect of a proposed dental procedure on the total health status of the patient.
  - Allied Health Practitioners- may conduct and update History and Physicals under the supervision of their Supervising physicians if they apply and are approved for such privileges through the privileging and credentialing processes. The history and physical exam and medical record documents must be co-signed by the supervising physician

#### SECTION 10. TELEMEDICINE PRIVILEGES

- a. All licensed medical staff members who have either total or shared responsibility for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site (the site where the patient is located at the time the service is provided) through one of the following mechanisms:
- i. The originating site fully privileges and credentials the practitioner according to standards set forth above in these bylaws,
  - ii. The originating site may use the distant site’s credentialing packet for privileging purposes if the distant site is a Medicare Participating Facility, and the privileging decision remains with the originating site. The Privileging process will review complaints concerning a potential applicant from the distant site.
- b. The Medical Executive Committee, based on department recommendations to the Credentials Committee, will recommend approval or disapproval of a request for telemedicine privileges to the Board for clinical services that are appropriately provided by the medical staff members through telemedicine links.

- c. The clinical services offered via telemedicine link will be consistent with the quality standards set forth at the originating site.

## SECTION 12. FOCUSED REVIEW OF INITIAL PRIVILEGES

Core Principle - All privileges initially granted to new members, held as temporary privileges, or granted as additional privileges to a current member, are subject to focused review.

- a. Focused review begins at the clinical department level - The relevant department or section chair will assign a proctor to conduct the focused review. Where proctoring is not feasible, focused review may include chart review, monitoring clinical practice patterns, simulation, external peer review and discussion with other individuals involved in the care of the member's patients. The department chair is responsible for monitoring the focused review and communicating with the practitioner.
- b. Completing the Focused Review - Before reappointment of any member, and by the end of the evaluation period or sooner if deviations from professional competence or conduct standards occur, the department or section chair will assess the proctoring reports as part of this peer review process.
- c. Satisfactory review of privileges - Where the practitioner has demonstrated acceptable performance in the requested privileges specifically requested, the relevant department chair will forward a recommendation to the credentials committee, and then forward to the Medical Executive Committee.
- d. Incomplete or unsatisfactory review - Where the focused review identifies individual, department or system wide deficiencies, further performance monitoring, corrective action, or other measures may be recommended by the department chair to the credentials committee and then forwarded to the Medical Executive Committee.
- e. Withdrawal of request for specific privileges - At any time during the focused review period a member may voluntarily withdraw the pending request for ~~any~~ specific clinical privileges without penalty or reporting obligation to NPDB.
- f. Relinquishing existing privileges - A Medical Staff member wishing to relinquish or limit previously granted clinical privileges must send written notice to the Medical Executive Committee the appropriate department chair(s) and Medical Staff Office specifying the clinical privileges to be relinquished or reduced. The request becomes effective 30 days after delivery to the Medical Staff office unless a later date is specified in the notice. A request to relinquish or limit clinical privileges before 30 days must be approved by the appropriate clinical department chair(s), and the President of the Medical Staff.

## SECTION 13. - ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

Core Principle - All privileges granted previously, and having undergone prior focused review are subject to ongoing professional practice evaluation. Ongoing professional practice evaluation is a peer review program that allows the medical staff to identify professional practice trends that impact on quality of care and patient safety on an on-going basis. Ongoing practice evaluation for employed and contracted physicians is evaluated by the same process.

Practitioner review – includes, but is not limited to the following:

- a. An evaluation of individual practitioner’s professional performance and includes opportunities to improve care based on standards established and maintained by the relevant department, based on recognized standards. It differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual practitioner’s performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a system.
- b. Practice evaluation using sources of information including but not limited to the review of individual cases; the review of aggregate data; and satisfaction of the medical staff’s clinical standards;
- c. Individual evaluation is a responsibility of the relevant clinical department, and is based on generally recognized standards of care, and approved by the medical staff under these bylaws. The process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional and technical and interpersonal skills in providing patient care.
- d. Clinical and performance data that is determined by individual departments and approved by the Medical Executive Committee.
- e. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges(s), and/or to recommend changes in systems operating in the clinical departments, medical staff or hospital to improve patient safety and care.
- f. External Review of members or non-member practitioners – may be required:
  - i. Where vague or conflicting recommendations arise from a practice evaluation, focused or ongoing professional practice evaluation.
  - ii. Where there is a lack of internal expertise within a clinical department.
  - iii. When requested in writing by any medical staff officer, department chair, or clinical department members.
  - iv. Where actual or potential conflicts of interest are present which may undermine the impartiality of the review process or impair decision making at the department level.

**ARTICLE VI  
CORRECTIVE ACTION**

Core Principle - The bylaws contain the exclusive means for review of and action regarding medical staff membership or privileges. Whenever there is reasonable grounds to believe the professional competence, or personal conduct of any member of the organized medical staff is considered below the standards set by the medical staff, a corrective action may be requested by any officer of the medical staff, the chief of any clinical department, by the chairperson of any standing committee of the medical staff, by the hospital Chief Executive Officer or designated representative, or by the hospital board.

**SECTION 1. PROFESSIONAL CONDUCT REVIEW –**

Includes review of actions, which may or may not implicate a change in membership or privileges.

a. Appropriate Conduct

Medical staff members are responsible for reporting errors that impact on the quality of care. For this reason, the following kinds of conduct by members are appropriate and therefore not restricted by these bylaws:

- i. Discussing quality of care concerns
- ii. Advocating for patients
- iii. Input that is meant to improve care
- iv. Input that is respectfully and constructively provided

b. Actionable Conduct

Actionable conduct may lead to restriction of privileges or loss of medical staff membership. Members' conduct is actionable under these bylaws if it includes but is not limited to the following:

- i. Harassment on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex or sexual orientation, and/or;
- ii. Verbal or physical abuse, directed against another person in their capacity as medical staff member, allied health professional, or house staff or privileges holder; hospital employee, contractor or volunteer, or patient.
- iii. Abuse of process includes but is not limited to:
  - a) Member retaliation against complainants or those implementing this process,
  - b) Failure or refusal to cooperate with this process, even if the underlying accusation is found to be untrue.
  - c) Abuse of the complaint process to harass other members is subject to corrective action under these bylaws. Abuse of the complaint process by employees, Board members or contractors is subject to discipline under hospital administrative policies.
  - d) Failure to adhere to the medical staff bylaws
  - e) Failure to adequately supervise assigned allied health professionals, or other individuals assigned to a member of the medical staff.
  - f) Failure to supervise assigned medical students, residents, other people in training

## SECTION 2. PROFESSIONAL CONDUCT REVIEW PROCEDURE

The conduct of everyone working in the hospital is subject to review. For members of the organized medical staff, the medical staff bylaws are the exclusive means for professional review. For hospital employees, including administrative personnel, nursing staff, and other business associates, conduct review, disciplinary procedures are established under existing hospital policy.

Complaints or other concerns raised about a member's practice are referred to the appropriate section or department chief to determine if the complaint or concern is baseless, if focused review is warranted, or to

refer the subject member immediately for evaluation and possible resolution. The subject of review is included early in the review process and as appropriate throughout, to promote the sharing of information. All recommendations are supported by findings and reported to the member and the Medical Executive Committee, specifying the standards at issue, deviations identified and steps that should have been taken and are recommended for future compliance and remediation. If appropriate under department standards, performance monitoring, corrective action or other measures are implemented or recommended.

Complaints of actionable conduct by a member of the medical staff are made in writing, and referred to any one of the following:

- \* Clinical department chair
  - \* President of the medical staff
  - \* Any officer of the medical staff
  - \* Administrative Medical Director, if available
- a. Submitting a complaint – All requests for corrective action are submitted in writing and presented to any of the following:
    1. The president of the medical staff, or
    2. The relevant department chair, or
    3. Medical Staff Office/ Administrative Medical Director/or designee, if available.
  - b. Initial Complaint Screening – All written complaints will be received by, or delivered to the Medical Staff Office/Administrative Medical Director, or designee. If available the Administrative Medical Director, or designee may, after review of the complaint in collaboration with the President of the medical staff may both agree that a complaint does not warrant a corrective action. If the Administrative Medical Director, or designee, is not available to review the complaint in a timely manner, the medical staff President and appropriate department chair will review the complaint and determine if a valid complaint exists.
  - c. Complaint Review Committee – Except for written complaints discharged through the initial complaint screening described above, all written complaints will be evaluated by a complaint committee comprised of the appropriate clinical department chairperson, president of the medical staff, and if available, the Administrative Medical Director, or designee. This committee will evaluate all written complaints to determine whether the complaint is credible, valid, and whether it warrants further evaluation, referral to the medical staff peer review committee, or referred for formal corrective action. The committee may, by a majority vote, elect to refer the subject of the complaint to the Medical Staff Wellness Committee or to forward the complaint to the medical staff peer review committee.
  - d. Non-actionable Conduct – Complaints not rising to the level of actionable conduct will be tracked for a period of 12 months by the Medical Staff Office
  - e. Actionable Conduct – Where a written complaint establishes a valid basis for formal review of professional competency or personal conduct, the following procedure will be initiated:
    1. A request for formal corrective action will be presented to the president of the medical staff.
    2. Within 14 days of receiving a request for corrective action, the president of the medical staff, in concert with the administrative medical director, or designee if available, or with the department chair if the Administrative Medical

Director/Designee is unavailable, will formally notify the affected member, by special notice, that a corrective action complaint has been received.

3. The subject of the complaint may within 14 days of being notified of the corrective action complaint, provide a written response to the president of the medical staff.
4. Either upon receiving the written response from the affected member, or the passage of 14 days, the president of the medical staff will formally notify the MEC that a request for corrective action has been received.
5. The MEC may elect to appoint an ad hoc committee to review the complaint or act on the complaint itself. If an ad hoc committee is appointed, it will investigate the complaint and provide a written report of its investigation to the MEC within 30 days of its formation.
6. The affected member and the MEC (or ad hoc committee if appointed by MEC) will meet within 7 days informally for the purpose of discussing the complaint, to assist in determining whether a valid complaint/request for corrective action exists. This meeting does not constitute a hearing, will be preliminary in nature, and none of the procedural rules provided in these bylaws applies. A written record of this meeting will be made.
7. Within 30 days after meeting with the subject of the complaint, or after receiving the written report from the ad hoc committee, the MEC will take action upon receipt of the request for corrective action. Such actions may include, without limitation:
  - a) To obtain further information necessary to evaluate complaint
  - b) To dismiss the corrective action.
  - c) To issue a warning letter, letter of reprimand or admonition.
  - d) To impose a focused review for a specified period of time without loss of privileges. Any such focus professional practice review will be supported by findings and reported to the member by the MEC, specifying the standards at issue, deviations identified, and steps that should be taken and are recommended for future compliance and remediation, as appropriate under clinical department standards of performance and monitoring.
  - e) To impose terms of probation that would not invoke automatic reporting to the national practitioner databank.
  - f) To summarily suspend, limit or modify the practitioner's membership or clinical privileges.
  - g) To modify, limit, or affirm an already imposed summary suspension of clinical privileges.
  - h) To recommend to the board actions that may result in the

reduction, suspension, or loss of medical staff membership or clinical privileges. Only those actions resulting in a change in membership status or involuntary loss of clinical privileges for more than 30 days entitle the affected practitioner to hearing and appeals rights under these bylaws.

8. Any recommendation by the MEC for reduction, suspension, or revocation of clinical privileges or for expulsion from the medical staff will entitle the affected practitioner to the fair hearing rights provided in these bylaws.
9. The president of the medical staff will promptly notify the Administrative Medical Director/or designee, in writing of all requests for corrective action received by the MEC, and will continue to keep the Administrative Medical Director/or designee fully informed of all actions taken. When the recommendation of the MEC is favorable to the practitioner, the President of the Medical Staff will promptly forward it, together with all supporting documentation to the designated representatives of the board for review and approval at its next regular meeting.
10. Any practitioner whose engagement by the hospital in an administrative capacity with related clinical responsibilities which require membership on the medical staff will be entitled to the same hearing rights accorded any other medical staff member when his/her medical staff privileges are terminated or otherwise adversely affected.
11. For the purpose of mandatory reporting to the National Practitioner Data Bank, a request for corrective action is considered to have been officially received at the time of the first formal MEC meeting following the submission in writing of a request for corrective action to the president of the medical staff.

### SECTION 3. SUMMARY SUSPENSION

- a. Whenever action must be taken because of imminent danger to the health or safety of any patient or any person, the chairman of the appropriate clinical department(s) in which the practitioner has privileges, or any of the Medical Staff Officers, have the authority to immediately suspend any or all portions of the clinical privileges of the affected practitioner. A summary suspension becomes effective immediately upon imposition. In the event that the clinical department chair or medical staff officers are unavailable, the Administrative Medical Director, who must be a physician and a member of the medical staff, may impose a summary suspension as permitted under these bylaws. The CEO of the hospital is notified of summary suspension within 24 hours and subsequently communicates this to the hospital governing board.
- b. A practitioner whose clinical privileges have been summarily suspended is entitled to request that the Medical Executive Committee hold a meeting on the matter within such reasonable time period thereafter as the Medical Executive Committee may be convened, but no later than 10 days after imposition of a summary suspension. The suspended practitioner will be permitted to attend to present information and respond to questions of the Medical Executive Committee members, but the meeting does not constitute a formal hearing, nor do the procedural rights established under these bylaws apply to such a meeting.

- c. The Medical Executive Committee may modify, continue, or terminate the terms of the summary suspension. If, as a result of such meeting, the Medical Executive Committee does not terminate the summary suspension, the affected practitioner is entitled to request a hearing and an appellate review, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee will remain in effect pending a final action on the matter by the Board.
- d. Immediately upon the imposition of a summary suspension, the President of the Medical Staff, responsible department chairman, or the Administrative Medical Director, if available, or designee will have authority to arrange for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients will be considered in the selection of such alternative practitioner.

#### SECTION 4. AUTOMATIC ACTION LIMITING OR REVOKING PRIVILEGES

Any event that invokes automatic suspension will require the Medical Executive Committee to convene a special meeting as soon as practical for the purpose of reviewing the factual circumstances, including any official reports from the relevant licensing body, DEA or other reporting body leading to the change in licensure or DEA status. If the automatic suspension was appropriately imposed, it does not give rise to hearing or appeal rights. The medical executive committee may take or recommend such further corrective action as appropriate, or may include termination of membership due to ineligibility, or may continue the automatic suspension until the member remedies the basis for the automatic suspension. The President of the Medical Staff or designee shall terminate an automatic suspension upon his/her review of documentation that establishes that the reason for the automatic suspension no longer exists. However, if an automatic suspension continues for more than 180 consecutive days, the member shall be deemed to have voluntarily resigned medical staff membership and/or the affected privileges.

Automatic suspension is invoked for:

- a. Failure to timely complete Medical Records. A temporary suspension of a practitioner's admitting privileges, effective until medical records are completed, will be imposed automatically after a failure to respond to a written warning of delinquency, or for failure to complete medical records in a timely fashion.
- b. Loss of Malpractice Insurance. For failure to maintain the amount of professional liability insurance required of the practitioner by these bylaws, a practitioner's medical staff membership and clinical privileges will be immediately suspended until he/she shows proof that the proper amount of professional liability insurance is in force.
- c. **Change in License to practice or DEA status –**
  - i. License – Whenever a practitioner’s license, certificate, or any other legal basis for medical practice is revoked, restricted, or suspended, the affected practitioner’s membership status and/or clinical privileges so affected will be immediately and automatically modified to fully comply with any such change in legal licensure status, subject to further action as may be taken under these bylaws.
  - ii. Change in DEA Status – Whenever a practitioner’s DEA number is revoked or suspended the member will be immediately and automatically subject to the same restrictions as it pertains to their rights to prescribe medications.

- d. Exclusion from government payment programs – will result in an automatic suspension all clinical privileges and membership status.
- e. Conviction of a felony – A Medical Staff member or AHP who is convicted of a felony, or pled “guilty” or plead “no contest” or its equivalent, in any jurisdiction, to a felony which has a relationship to the member’s or AHP’s qualifications, function, duties, or ethical conduct, shall immediately and automatically be suspended from practicing at the Hospital. Whether a felony has a relationship to the member’s or AHP’s qualifications, function, duties, or ethical conduct shall be determined by the MEC. Such suspension is effective on conviction and does not await the results of an appeal or the conviction otherwise becoming final.

**ARTICLE VII**  
**Medical Staff Hearing and Appellate Review Procedure**

The right to a hearing or appeal arises any time when a practitioner entitled to the hearing and appeal process under these bylaws is notified either by the Medical Executive Committee or by the Board of actions that could result in a change in membership status or an involuntary change in their current clinical privileges. All hearings and appellate reviews are in accordance with the procedural safeguards set forth in these bylaws. As used in these provisions for hearing and appeal rights, the process applies solely to physicians, dentists, and podiatrists, and includes applicants for medical staff membership and temporary privileges holders. In this setting, the term practitioner refers only to those medical professionals entitled to membership on the St. Lukes medical staff.

**SECTION 1. RIGHT TO HEARING AND TO APPELLATE REVIEW**

- a. When any practitioner receives notice of a recommendation of the Medical Executive Committee that, if ratified by decision of the Board, will adversely affect the practitioner's appointment to or status as a member of the medical staff or exercise of clinical privileges, the practitioner will be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the ad hoc committee to the Medical Executive Committee following such hearing is adverse to the affected practitioner, the practitioner will be entitled to an appellate review by the Board, prior to a final Board decision on the matter.
- b. The practitioner is entitled to a hearing or appellate review when he or she receives a:
  - i. notice of an adverse decision by the Board affecting the practitioner’s appointment to or status as a member of the medical staff,
  - ii. notice of an involuntary reduction in the practitioner’s exercise of clinical privileges, or
  - iii. Adverse decision by the Board regarding membership status or clinic privileges overturning in whole or in part a favorable recommendation by the Medical Executive Committee
- c. All hearings and appellate reviews will be in accordance with the procedural safeguards set forth in these bylaws.

**SECTION 2. NOTICE OF ADVERSE RECOMMENDATION AND REQUIREMENT TO RESPOND**

- a. Notice to the Member - The President of the Medical Staff is ~~will~~ responsible for giving prompt special notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing. This notice will:
  - i. Inform the affected practitioner of the reasons for the proposed action and his/her right to a hearing and/or appellate review pursuant to these bylaws,
  - ii. Specify that he/she will have thirty (30) days following the date of receipt of such notice within which to request a hearing,
  - iii. State that failure to request a hearing within the specified time period will constitute a waiver of the practitioner's right to same,
  - iv. State that upon timely receipt of the practitioner's request, the practitioner will be notified of the date, time, and place for a hearing and the grounds upon which the adverse action is based, and
  - v. Inform him/her of the rights under these bylaws.

### SECTION 3. WAIVER OF HEARING OR APPEAL RIGHTS

A practitioner who fails without good cause to appear and proceed at such hearing ~~will~~ is deemed to have waived his/her hearing and appeal rights and to have accepted the adverse recommendation or decision involved, and the same will there upon become and remain in effect as otherwise approved in these bylaws for waivers. Waiver extinguishes any other hearing or appeal rights under these bylaws and is considered the same as affirming a final adverse Board decision against the practitioner. A practitioner waives his/her rights to a hearing or appeal whenever:

- a. The practitioner fails, without good cause, to request in writing a hearing or appeal within the time limits set forth in these bylaws.
- b. A practitioner fails, without good cause, to appear at a scheduled hearing. A practitioner who fails, without good cause, to appear and proceed at such hearing will be deemed to have waived his/her rights.

### SECTION 4. NOTICE OF HEARING

- a. Practitioners not under suspension – Within seven (7) days after receipt of a request for hearing from a practitioner entitled to the same, the Administrative Medical Director, or designee if available and consistent with these bylaws will schedule and arrange for such a hearing to take place within thirty (30) days from the date of receipt of the request for hearing. In the absence of an AMD, the President of Medical Staff will schedule a formal hearing.
- b. Practitioners who are under suspension – A hearing for a practitioner who is under suspension which is then in effect will be held as soon as arrangements therefore may be reasonably made, but not later than seven (7) days from the date of receipt of such a practitioner's request for a hearing unless extended by the practitioner.
- c. The President of the Medical Staff will notify the practitioner by special notice of the following:
  - i. The time, place, and date of the hearing,

- ii. In concise language, a detailed description of the evidence of acts or omissions considered in making the adverse recommendation or decision,
- iii. A list of specific or representative charts that are the subject of, or relevant to the hearing process,
- iv. The list of witnesses (if any) expected to testify at the hearing on behalf of the professional review body. In turn, the practitioner will provide a list of witnesses expected to testify on behalf of the practitioner within fifteen (15) days, if not under suspension, or within 4 days if under suspension.

## SECTION 5. COMPOSITION OF HEARING COMMITTEE

- a. Hearing Committee –all hearings are conducted by an ad hoc committee of not less than three (3) members of the medical staff appointed by the President of the Medical Staff, who are not in direct competition with the affected practitioner. The hearing committee is subject to the following rules:
  - i. All committee members are subject to the conflict of interest rules of these bylaws.
  - ii. Only non-alternate committee members are entitled to vote.
  - iii. Alternate committee member must attend all hearings.
  - iv. Alternates are not entitled to vote unless they are required to replace another committee member.
- b. Hearing committee restrictions -\_No staff member who has actively participated in consideration of the adverse recommendation will be appointed a member of this hearing committee.
- c. Hearing Officer - is selected by the President of the Medical Staff and approved by the Medical Executive Committee from a list of individuals with documented experience in the hearing process. The hearing officer may not be selected from a law firm or an organization regularly utilized by the hospital, the medical staff, or the affected medical staff member or applicant for membership.
- d. The physician advocate – The affected practitioner will be entitled to be accompanied *either by an attorney, or be* represented at the hearing by another person of his/her choice.
- e. The Medical Executive Committee advocate – The Medical Executive Committee, when its action has prompted the hearing, will appoint one of its members to represent it at the hearing to present the facts in support of its adverse recommendation and to examine witnesses. The Medical Executive Committee may also be represented by an attorney.
- f. The Board Advocate - When its action has prompted the hearing, the governing body will appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. The Board may be represented by an attorney.

## SECTION 6. CONDUCT OF HEARING

- a. Hearing officer – will preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

- b. Procedural rules -
- i. Rules of evidence – The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs will be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held will, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact, and such memoranda will become a part of the hearing record.
  - ii. Rights of the parties – To call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness, and to rebut any evidence. If the practitioner does not testify in his/her own behalf, the practitioner may be called and examined as if under cross- examination.
- c. Attendance – All members of the hearing committee must be present at all times when the hearing takes place and no member may vote by proxy.
- d. Personal appearance of the practitioner – The personal presence of the practitioner for whom the hearing has been scheduled is required.
- e. The burden of proof –
- i. Except in the case of an initial applicant denied membership and privileges on the medical staff, it will be the obligation of the Medical Executive Committee (or Board, if its action is the reason for the hearing) to persuade the hearing committee, by a preponderance of the evidence presented, that its recommendation is reasonable and warranted. The affected practitioner will thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by showing that the Medical Executive Committee (or Board if it has initiated the hearing) has not met its burden of proof, or that such basis or any action thereon is either arbitrary, unreasonable, or capricious.
  - ii. In the case of an initial applicant denied privileges and membership on the medical staff, the applicant will bear the burden of persuading the hearing committee, by a preponderance of the evidence, of the applicant’s qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant’s current qualifications for membership and privileges.
- f. Hearing Recess – The hearing committee may at its own discretion and without prior notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.
- g. Recordkeeping – A permanent record of the hearing must be kept. The method of recording will be established by the ad hoc committee and may be accomplished by use of a court reporter or electronic recording unit.
- h. Closing the hearing process – Upon conclusion of the presentation of oral and written evidence, the hearing will be closed. Both parties have the right to submit a written statement at the close of the hearing. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations in private.

- i. Final hearing committee report and recommendations – Within twenty (20) days after closure of the hearing, the hearing committee will make a written report and recommendation approved by the majority of the committee, based upon evidence produced at the hearing and will forward the same together with the hearing record and all other documentation to the practitioner, and the Medical Executive Committee or the Board, whichever recommended the adverse action. The report may recommend confirmation, modification or rejection of the original adverse recommendation of the Medical Executive Committee and/or decision of the Board. Together with the report, recommendation, hearing record, and other documentation, the President of the Medical Staff will inform the affected practitioner, by special written notice of their rights to appeal and in the appeals. minority report may also be submitted to the Board by any voting member(s) of the hearing committee. The hearing officer will attest, by signature, that the record and the final recommendation represents a fair and complete record.
- j. Copies of the proceedings – The affected practitioner has a right to one written copy of the record made of the proceedings. Additional written copies may be obtained from the Medical Staff Office by the practitioner upon payment of any reasonable charges associated with the preparation thereof. A permanent copy of the proceedings will be securely maintained and stored by the Medical Staff Office.

## SECTION 7. APPEAL TO THE BOARD

The Board or its appointed appellate review committee will act as the appellate body. It will review the record created in the proceedings and will consider the written statements submitted pursuant to these bylaws for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was reasonable and warranted.

- a. Request for appellate review – Within ten (10) days after receipt of a notice of an adverse recommendation or decision by a hearing committee the practitioner or Medical Executive Committee may, by special notice to the Board, request an appellate review by the Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the parties' written statement provided for below, or may also request that an oral argument be permitted as part of the appellate review.
- b. Waiving the right to appeal – If such appellate review is not requested as specified in these bylaws, the parties will be deemed to have waived the right to the same, and to have accepted such recommendation or decision. If the recommendation or decision upholds a Board action, that action becomes final if not appealed.
- c. Timing of the Appeal – Within seven (7) days after receipt of such notice of request for appellate review, the Board will schedule a date for such review, including a time and place for oral argument if such has been requested, and will notify all parties through the President of the Medical Staff by special notice.
  - i. Practitioners under suspension – When the practitioner requesting the appellate review is under a suspension which is then in effect, such review will be scheduled as soon as the arrangements for it may reasonably be made, but not more than seven (7) days from the date of the receipt of such notice unless extended by the practitioner.

- ii. Practitioners not under suspension – The date of the appellate review will not be less than fifteen (15) days, nor more than forty-five (45) days from the date of receipt of the notice of request for appellate review.
- d. Conduct of the appellate review – The appellate review will be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than three members subject to the conflict of interest policy of the Board. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, will be introduced at the appellate review only under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review will, in its sole discretion, determine whether such new matters will be accepted.
- e. Access to the record – All parties will have access to the report, record, and transcription of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision.
- f. The right to submit a written report – All parties have the right to submit a written statement containing objections to the findings of fact, conclusions and procedural rulings together with the reasons therefore, and addressing any matters raised at any step in the hearing process. The statement will be submitted to the appellate review body through the President of the Medical Staff at least ten (10) days prior to the scheduled date of the appellate review, unless the time limit is waived by the review body. The President of the Medical Staff will provide a copy to the other party immediately upon receipt of the statement, or as soon as practicable thereafter.
- g. Oral arguments – If oral argument is requested as part of the review procedure, the affected practitioner will be present at such appellate review, will be permitted to speak against the adverse recommendation or decision, and will answer questions put to him/her by any member of the appellate review body. The Medical Executive Committee will also be represented by an individual who will be permitted to present oral arguments before the Board or appellate body. Both the practitioner and the Medical Executive Committee may be represented by an attorney.
- h. Board Decision - If the appellate review is conducted by the Board, the Board may affirm, modify, or reverse the recommendation of the hearing committee, or in its own discretion, refer the matter back to the hearing committee for further review and recommendations. Such referral may include a request that the hearing committee conduct further hearings to resolve specified disputed issues within a reasonable period.

## SECTION 8. FINAL DECISION BY BOARD

- a. Timing - For matters in which the Board conducted the appellate review, within five days after the conclusion of the appellate review, the Board will make its decision on the appeal. For matters in which an appellate review committee conducted the appellate review, the appellate review committee must submit their report to the board within five days after the conclusion of the appellate review. The Board will make its decision within five days after receipt of the written report of the appellate review committee. The action of the Board is final.
- b. Notice of final action - The affected practitioner and the Medical Staff President will be sent by special notice a report of the final decision within five business days by the Board, including a statement of the basis for the decision. The Medical Executive Committee will receive a report of the action at its next meeting.

- c. Reporting - When a final decision on a corrective action matter adversely affects a practitioner, reports will be sent to the relevant Boards of Medicine and the National Practitioner Data Bank as required by law. The reports will be written by the hearing or appeal committee responsible for recommending the action approved by the Board, with assistance from the medical staff legal counsel.
- d. Review of Report - Whenever action is taken pursuant to these Bylaws which action requires a report to be made to the Board of Medicine or the National Practitioner Data Bank, such report will be reviewed for accuracy by the Medical Staff legal counsel, the chairman of the department in which the practitioner is associated, and the President of the Medical Staff prior to filing the report.

**ARTICLE VIII**  
**Medical Staff Officers, Representatives, and Administrative Staff**

**SECTION 1. OFFICERS OF THE MEDICAL STAFF**

The officers of the medical staff will be:

- i. President
- ii. Vice President (President-elect)
- iii. Secretary-Treasurer
- iv. Immediate Past President

**SECTION 2. QUALIFICATIONS OF OFFICERS**

Officers must have been members of the active medical staff for at least 2 years at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status will immediately create a vacancy in the office involved.

**SECTION 3. ELECTION OF OFFICERS –**

- a. Officers are elected at the annual meeting of the medical staff. Only eligible voting members of the medical staff may vote to elect medical staff officers.
- b. The nominating committee consists of the available most immediate past three presidents of the medical staff. The committee will offer one or more nominees.
- c. The slate of candidates is reviewed and approved by the MEC the month prior to the annual meeting.
- d. Medical staff members may vote by any of the following methods as determined by the MEC: (re-paragraphed)
  - i. Submitting a double envelope secret written ballot to the Medical Staff Office prior to the meeting. Secret written ballots are prepared by the medical staff office and sent to all voting members prior to the meeting.

- ii. By attending the annual meeting an eligible voting member may vote in person or abstain from voting.
  - iii. An eligible voting member of the medical staff not attending the annual meeting and not voting by secret ballot may vote by submitting a signed written proxy-giving his/her vote to a member that is attending the meeting. The written proxy statement must be submitted to the Medical Staff Office prior to the annual meeting.
- e. Quorum - A quorum at the annual meeting is 30% of all eligible voting members either present in person at the general medical staff meeting, by written proxy, or by written secret ballot. Officers are elected by a majority vote.

#### SECTION 4. TERM OF OFFICE

All officers serve a one-year term from the election date or until a successor is elected. Officers will take office on January 1<sup>st</sup> following the annual meeting. Removal of an officer during his/her term of office can occur under the following circumstances, which may include, but is not limited to the following:

- a. Failure to uphold the interests of the medical staff.
- b. Failure to fulfill the duties of the office.
- c. Failure to adhere to the standards of professional conduct or competency required by these Medical Staff Bylaws.
- d. Failure to uphold and enforce the obligations and responsibilities required by these bylaws.

#### SECTION 5 - PROCESS OF REMOVAL FROM OFFICE –

Any officer may be removed during their term of office by the following mechanism;

- a. Any eligible voting member of the medical staff may request initiation of the formal removal process of any officer by submitting a petition for removal signed by at least 30% of the eligible voting members, or:
- b. By the majority vote in support of a motion for initiating the removal of an officer at any special meeting of the medical staff where a quorum is present in person or by proxy, or;
- c. At the annual meeting where a quorum is present as defined by these bylaws, by a majority vote.
- d. If by the above steps there is an affirmative vote to initiate the removal of a medical staff officer, the MSO will, within 5 days send double envelope secret ballots to all eligible voting members of the medical Staff presenting the question of whether or not to remove the named officer from their leadership position. All eligible voting members will submit their secret written ballot to the Medical Staff Office within 2 calendar weeks following mailing of these ballots. The Medical Staff Office will collect the ballots, and the MEC is responsible for opening and counting the written ballots. To produce a quorum for action, at least 30% of eligible voting members must vote by secret ballot to authorize removal of an officer. Where a quorum is achieved, a majority of those submitting ballots is required to remove an officer. If there is an affirmative vote to remove an officer from medical staff leadership, the MEC will immediately inform this person of the decision by special written notice. The

removal from office is effective immediately. The MEC will appoint a replacement for the affected position according to these bylaws.

## SECTION 6 - RESIGNATION FROM OFFICE

An Officer may tender his/her resignation in writing to the MEC, effective immediately or upon a date specified in the letter. Any officer receiving a statement of resignation from a medical staff officer must submit a written statement to the MEC within five working days of having received notice of intent to resign. Failure of a medical staff officer to withdraw the resignation within five days serves as confirmation of the resignation.

## SECTION 7 - VACANCIES IN OFFICE

- a. Vacancy of the president of the medical staff – the vice president of the medical staff will immediately assume the office of president following the resignation or removal of the medical staff president.
- b. Vacancy of all other medical staff officers will be done according to the following process:
  - i. The MEC will appoint a replacement officer who will serve for the remaining term.
  - ii. Upon completion of the temporary term of office, the office will be filled through the election of officers as described by these bylaws.
  - iii. Any medical staff member serving as a temporary officer may be nominated by the Nominating Committee to serve a subsequent term in the same position.
  - iv. No medical staff officer may succeed themselves in a specific elective leadership position for more than one additional consecutive elected term.

## SECTION 8. DUTIES OF OFFICERS

During their terms of office, medical staff officers are supplied with access to work and meeting space, medical staff support staff, and email and intranet as available to the hospital administration, for the sole purpose of carrying out the duties of their offices.

- a. President. The president serves as the chief administrative officer of the medical staff, to :
  - i. Act in coordination and cooperation with the CEO or his/her representative in all matters of mutual concern within the hospital;
  - ii. Call, preside at, and be responsible for the agenda of all general meetings of the medical staff;
  - iii. Serve as chairman of the Medical Executive Committee;
  - iv. Serve as ex officio member of all other medical staff committees;
  - v. Be responsible for the enforcement of medical staff bylaws, rules, and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance

with procedural safeguards in all instances where corrective action has been requested against a practitioner;

- vi. Appoint committee members to all standing, special, and multi-disciplinary medical staff committees except the Medical Executive Committee;
  - vii. Represent the views, policies, needs, and grievances of the medical staff to the Board and to the CEO;
  - viii. Receive and interpret the policies of the Board to the medical staff and report to the Board on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to assure the quality of health care;
  - ix. Be responsible for the educational activities of the medical staff, and
  - x. Be the spokesman for the medical staff in its external professional public relations.
- b. Vice President (President-elect). In the absence of the president, he/she will assume all duties and have the authority of the president. The vice president will be a member of the Medical Executive Committee. Except as otherwise provided in the bylaws, he/she may succeed the president if nominated by the nominating committee when the president's term expires or automatically succeed for the remainder of the unfulfilled term if the President steps down from office for any reason.
  - c. Secretary-Treasurer. He/she will be a member of the Medical Executive Committee. The secretary will keep accurate and complete minutes of all medical staff meetings, call medical staff meetings on order of the president, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office.
  - d. The immediate past president of the medical staff will continue to serve on the Credentials Committee and the Nominating Committee for three years. They will serve on the Quality of Care Committee of the Hospital Board for one year.

#### SECTION 9. MEDICAL STAFF LEADERS SERVING ON THE HOSPITAL BOARD -

In addition to the President of the Medical Staff and the Vice President of the Medical Staff, if the Board requests additional Medical Staff appointments, they will be elected at the annual meeting of the Medical Staff from the membership at large.

#### SECTION 10. MEDICAL STAFF ADMINISTRATIVE SUPPORT

Medical staff administrative staff includes the Administrative Medical Director/designee and support staff. Although they are hospital employees, they carry out the administrative roles as outlined in these bylaws.

- a. Support Staff Responsibilities – duties of the medical staff administrative staff are reviewed by the Medical Executive Committee in its advisory role to hospital administration, and to facilitate cooperation between the hospital and the medical staff.
- b. Selecting Administrative Support Staff - The CEO will coordinate candidate interviews for the Administrative Medical Director/designee with representatives of the medical staff leadership, who provide feedback to the CEO on all candidates.

- c. Removal of Administrative Support Staff - The Medical Executive Committee or the medical staff may, as permitted by these bylaws and for identified cause, recommend to the CEO the removal of the Administrative Medical Director/or Designee position due to a lack of confidence or failure to perform the duties as outlined in these bylaws. Prior to removing the Administrative Medical Director, the CEO will meet and discuss the action with the Medical Executive Committee.

## **ARTICLE IX CLINICAL DEPARTMENTS**

### **SECTION 1. ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS**

Departments of the medical staff will be as follows: Anesthesiology, Cardiovascular Medicine, Dental-Oral Surgery, Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics-Gynecology, Ophthalmology, Orthopedics, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Podiatry, Psychiatry, Radiology, Surgery and Urology. Each department will be organized separately and will elect a chairman responsible for its clinical work.

All departments may divide into subspecialty sections but a minimum of three (3) members are required to form such sections. Any subspecialty section with ten (10) or more members may request recognition as a separate department of the medical staff with representation on the Medical Executive Committee as set forth in these bylaws. If membership of a department drops below ten (10), Medical Executive Committee representation is forfeited, effective the beginning of the next year except for those departments with less than ten members that existed prior to 2007.

### **SECTION 2. QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT CHAIRMAN AND SECTION CHIEFS**

- a. Each chairman or chief will be a member of the active staff qualified by training, experience and demonstrated competence for the position. Every chairman or chief will be board certified by an appropriate specialty board or be determined by the Medical Executive Committee to have comparable competence.
- b. Each chairman or chief will be elected by a simple majority of the department or section for a two-year term.
- c. Removal of the chairman or chief during his/her term of office may be initiated by a majority vote of all active staff members of the department. Grounds for removal will be the same as required for removal of medical staff officers in Section 4 of Article VIII.

### **SECTION 3. ROLES & RESPONSIBILITIES OF DEPARTMENT AND SECTION LEADERSHIP**

Each chairman is:

- a. Responsible for implementing a process for the continuous assessment and improvement of the quality of care and services provided by the department/service, assuring that quality control programs are maintained, and participates in the evaluation, and assures the continuing surveillance of, the professional performance of all individuals with clinical privileges in the department;

- b. A member of the Medical Executive Committee, giving guidance on the overall medical policies of the hospital, making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care, and working to assure the department's integration into the primary functions of the organization.
- c. Responsible for enforcing of the medical staff bylaws, rules and regulations within his/her department;
- d. Responsible for implementing actions, decisions, or duties imposed upon the department by the MEC;
- e. Required to forward to the MEC his/her department's recommendations concerning the staff classification, reappointment, and the delineation of clinical privileges for all practitioners in his/her department;
- f. Responsible for evaluating the qualifications and competence of all department and section personnel, including allied health professionals, who provide patient care, treatment and services;
- g. Responsible for establishing and reporting to the Medical Executive Committee on the criteria for clinical privileges in their department, and assessing the need for space and other resources needed in their department;
- h. Required to arrange for the orientation of all persons in the department, and the teaching, educational, and research program in his/her department;
- i. Actively involved in every phase of administration of his/her department and in all matters affecting patient care through coordination with the nursing service and the hospital administration;
- j. Involved in evaluating and recommending to the hospital off-site sources for needed patient care, treatment and services not provided within the department or the hospital;
- k. Responsible for the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Medical Executive Committee;
- l. Responsible for coordinating all interdepartmental and intradepartmental services;
- m. Responsible for developing and implementing policies and procedures that guide and support the provision of care, treatment and services;
- n. The chair of departmental meetings and is responsible to call all departmental meetings.

Each chief will:

- a. Call and chair section meetings; and
- b. Carry out other duties as assigned by the department chair or Medical Executive Committee.

#### SECTION 4. FUNCTIONS OF DEPARTMENTS

Core Principle - Consistent with these bylaws, rules, regulations and policies of the medical staff, each clinical department will establish a criteria for granting clinical privileges and for the holding of office in the department.

- a. **Recommending Privileges** - Where more than one department can grant similar or overlapping privileges - No clinical department may make a policy affecting the medical practice of members in any other clinical department without timely notification of all affected departments and approval of any such policy by the credentials committee and the MEC.
- b. **Emergency Call Coverage** - Each clinical department must determine the following:
  - i. How its members provide on call services to the Emergency Department consistent with departmental resources, available personnel, and the clinical needs of the facility.
  - ii. The department will provide;
    - a) A written on call roster to the ED as required by these bylaws, rules and regulations, and under EMTALA rules,
    - b) A list of departmental personnel available for call duties on an assigned or voluntary basis,
    - c) A copy of the department on call policy to the MEC.
- c. **Departmental evaluation of quality indicators** – the department will identify:
  - ii The important aspects of care for the department;
  - iii. Which specific clinical indicators are used to evaluate and monitor the quality and appropriateness of the important aspects of care; and
  - iv. How departmental peer review activities affect the quality and appropriateness of care provided by all department members and supervised allied health professionals.
- d. **Department Meetings** - Each department establishes its own meeting frequency to review and analyze on a peer-group basis the clinical work of the department.
- e. **Departmental Reports** - Each department reports to the MEC on at least a quarterly basis its review of patient care within the department.
- f. **Department Peer Review Activities** – Each department will evaluate the professional practice activities of its members and respond to questions of professional competency or personal conduct as required by these bylaws.
  - i. Where a practitioner is required to provide information about specific case management or professional activities, the department chair or their designated representative will notify the affected practitioner in writing of the need to have the member attend a department meeting for the purpose of discussing individual case management or personal conduct matters.
  - ii. The department chair or their representative schedules a meeting for the purpose of discussing the professional practice or conduct issues leading to this meeting. The affected member will be provided with detailed information about the nature of any complaint or practice issue leading to the meeting.

- iii. Any meeting to review practitioner conduct or competency may not be postponed for more than 30 days absent a good faith written request for such a postponement from the affected practitioner.
- iv. Department members are expected to assist in the timely resolution of any clinical practice or professional conduct issues.
- v. Failure to reasonably assist the department peer review and quality of care activities necessary for a review and evaluation of professional conduct or competency may give rise to corrective action against a member of these bylaws.
- vi. Quality of care issues not resolved by this process – where professional practice or conduct issues cannot be resolved at the department level, the MEC will be notified of the matter. The MEC will determine whether to directly resolve the issue or to refer the matter to the medical staff physician peer review committee for evaluation and resolution.

**ARTICLE X  
MEDICAL STAFF COMMITTEES**

**SECTION 1. TYPES AND OPERATIONS OF COMMITTEES**

- a. Committees are designated as either standing or special. All committees other than the Medical Executive Committee are appointed by the President of the Medical Staff. No policies may be promulgated by any committee until submitted to, and approved by the Medical Executive Committee.
- b. Standing committees - include, but are not limited to the following:
  - i. Medical Executive Committee
  - ii. Medical Staff Wellness Committee
  - iii. Credentials Committee
  - iv. Bylaws Committee
  - v. Performance Improvement Committee
  - vi. Pharmacy and Therapeutics Committee
  - vii. Physician Peer Review Committee
  - viii. Clinical Management Committee
- c. Special Committees - are ad hoc committees appointed by the President of the Medical Staff, or the Medical Executive Committee. Special committees confine their work to the purpose for which they are appointed and report directly to the Medical Executive Committee. The Medical Executive Committee reviews the need and purpose(s) for each special committee at least annually. The MEC may at its discretion change the purpose, membership, or continued operation of any special committee as permitted under these bylaws. The functions, composition, staff and accountabilities of each

special committee will be stated in the minutes of the Medical Executive Committee when established by the Medical Executive Committee.

- d. Requests to change committee members - Any medical staff member may submit a written request to the MEC for the purpose of adding or removing medical staff on any standing or special committee which he/she feels is not functioning properly or fairly. The MEC will review all such requests at its first subsequent meeting and will make a final recommendation within 30 days.
- e. Committee Minutes - Complete and accurate minutes for all committee meetings will be maintained.
- f. Resignation - A committee member may resign for any reason from any committee, effective immediately or upon a date specified, by writing, or verbally stating, to an officer or the committee chairman the intent to resign. Any verbal resignation will be immediately documented by the person receiving the resignation, with a copy to the resigning member. Failure to withdraw the resignation within five days serves as confirmation of the resignation.
- g. Committee Executive Session - At the call of its chairman, any medical staff committee or department, or the medical staff as a whole, may meet in executive session, with attendance restricted to medical staff members, a recording secretary, and such advisors or other attendees as the chairman may specifically request to attend.

## SECTION 2. MEDICAL EXECUTIVE COMMITTEE

- a. Composition. All members of the Medical Executive Committee hold an unrestricted Iowa medical license, and are members of the active medical staff. The MEC consists of the officers of the medical staff, the chief of each clinical department, the director of medical education, and the immediate past three presidents of the medical staff. The MEC may appoint up to two non-voting allied health professionals to the MEC to serve in an advisory capacity to assist in MEC functions impacting on allied health professionals practice within the hospital. Each member of the Medical Executive Committee has one vote. Removal of an MEC member is permitted for just cause as described under these bylaws. Just cause includes, but is not limited to the failure to uphold the interests of the medical staff, adhere to the duties and obligations imposed under these bylaws, and/or a failure to carry out the duties of the office.
- b. Duties. The duties of the Medical Executive Committee include:
  - i. Acting on all matters of medical staff business between meetings of the general medical staff, except for election of general staff officers, removal of medical staff officers, and adoption of amendments of these medical staff bylaws;
  - ii. To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;
  - iii. To coordinate the activities and general policies of the various departments;
  - iv. To receive reports and takes action on quality management findings or direct other action-taking officials or components of medical staff to act on and/or further evaluate quality management findings; monitor substance, timeliness and effectiveness of actions taken;
  - v. To report to the Board on the quality of care delivered as demonstrated in the quality management activities;

- vi. To receive and act upon committee and department reports;
  - vii. To coordinate, or oversee coordination of, the activities of and policies adopted by the medical staff, departments and other clinical units and committees;
  - ix. To implement and monitor policies of the medical staff, or monitor that such policies are implemented by the departments and other clinical units;
  - x. To provide liaison between medical staff and the CEO and the Board;
  - xi. To provide recommendations ~~action~~ to the CEO on matters of a medico-administrative nature;
  - xii. To make recommendations on hospital management matters to the Board through the CEO or designee;
  - xiii. To fulfill the medical staff's accountability to the Board through the CEO;
  - xiii. To ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;
  - xiv. To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
  - xv. To review the credentials of all applicants and to make recommendations for staff membership, assignments to department, and delineation of clinical privileges to the Board;
  - xvi. To periodically review all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and, as a result of such reviews, to make recommendations for re-appointments and renewal or changes in clinical privileges;
  - xvii. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the medical staff, including the initiation of and/or participation in medical staff corrective actions or peer review activities when warranted;
  - xviii. To report at each general staff meeting; and
  - xix. To perform other functions as required by the Medical Staff Bylaws.
  - xx. To promptly resolve quality of care issues arising within clinical departments that are not successfully resolved at the department level, or where clinical departments are unable to resolve issues of professional practice or professional conduct that have not been timely resolved at the department level.
- c. Meetings. The Medical Executive Committee will meet at least once a month and maintain a permanent record of its proceedings and actions.
- d. Procedure to overturn an action of the Medical Executive Committee. Except for actions of the Medical Executive Committee related to peer review, under these bylaws, any action or

recommendation of the Medical Executive Committee may be overturned by a majority vote of the active and refer and follow medical staff through the following procedure:

- i. Any member of the medical staff may make a written request for a vote to overturn actions or recommendations of the Medical Executive Committee. Any such request will be submitted to the President of the Medical Staff no later than 180 days from the Medical Executive Committee action that is the subject of the controversy.
- ii. The request for a vote to overturn an Medical Executive Committee action must be approved, either by a majority vote of active and refer and follow medical staff members physically present or by proxy at any regular or special meeting where a quorum is present as described in these bylaws, or by a petition, submitted to the President of the Medical Staff signed by at least 25% of the active and refer and follow medical staff.
- iii. If the request for a vote to overturn an MEC action is approved, the vote to overturn may be undertaken at any regular or special meeting of the medical staff.
- iv. At least 15 days before any such meeting to overturn a Medical Executive Committee action, all active and refer and follow members of the medical staff will be provided with written notice of the meeting notifying all members of the time and place of the meeting, and will include a written proxy.
- v. All voting will be either in person, by secret ballot, or by delivering the signed written proxy to the Medical Staff Office prior to the meeting.
- vi. A vote to overturn an Medical Executive Committee action requires ~~the~~ an affirmative vote to overturn by a majority of the members of the active and refer and follow medical staff present in person or voting by secret ballot or by written proxy after receiving votes from at least 30% of eligible voting members.

### SECTION 3. MEDICAL STAFF WELLNESS COMMITTEE

The Medical Staff Wellness Committee exists to proactively assist medical staff members on matters of individual physical and mental health in a non-punitive environment respecting individual privacy and confidentiality. The Wellness Committee functions to assure that all members of the medical staff provide patient care with reasonable skill and safety unaffected by physical or mental disorders or disabilities.

The Committee consists of the Administrative Medical Director/designee if available and two additional members of the medical staff as chosen by the President of the Medical Staff. If the AMD position is no longer filled then the MEC will appoint one additional member to the Wellness committee. At least one individual should have experience in behavioral health and/or substance abuse evaluation and treatment. The term of service will be determined by the Medical Executive Committee. No member of the Wellness Committee will serve on other peer review committees.

### SECTION 4. PEER REVIEW COMMITTEE

In reviewing the clinical activities or professional conduct of practitioners, whether members of the medical staff or as non-members granted privileges in the hospital, the Peer Review Committee will act in good faith

in the review of all practitioners, subject to the restrictions imposed by the Conflict of Interest section in these bylaws.

Any practitioner who is the subject of review by the Peer Review Committee has the right to review and appeal of the Peer Review Committee actions that alter their membership or affiliate status, or results in any involuntary change in clinical privileges for more than 30 days, if reportable to the NPDB. The Peer Review Committee will make good faith efforts to satisfy the obligations imposed by the HCQIA, and to comply with relevant State and Federal Law in the conduct of the committee.

Peer review activities are ongoing for all practitioners, and the review process includes review at the clinical department level such as FPPE (focused professional practice evaluation), OPPE (ongoing professional practice evaluation), and may include actions under the Corrective Action section of these bylaws. However, there are circumstances in which peer review activities cannot be accomplished at the department level, or by other medical staff or hospital committees, and in these circumstances the requirement for individual practitioner review will be performed by the Peer Review Committee.

#### SECTION 5. CREDENTIALS COMMITTEE

The Credentials Committee is comprised of seven members of the active medical staff, to include the immediate 5 past presidents, if available. Additional members may be appointed by the President of the Medical Staff. The Committee receives evaluations and recommendations for every member of, or applicant to the medical staff. The Credentials Committee reviews the qualifications, evaluations and recommendations for each practitioner applying for initial appointment or reappointment, and for initial, modified, or continuing clinical privileges. After such review, the committee submits reports and recommendations to the MEC on the qualifications of each practitioner applying for staff membership or clinical privileges. Each report will include specific recommendations for appointment, membership, category of membership, department affiliation, setting specific clinical privileges, and any other special conditions affecting membership status and/or clinical privileges. The Committee meets at the call of its chairman and at least bimonthly. A permanent record of its proceedings and actions will be maintained by the medical staff office and is reported to the Medical Executive Committee.

#### SECTION 6. BYLAWS COMMITTEE

The Bylaws Committee is comprised of seven voting members of the medical staff selected jointly by the President of the Medical Staff and the current chairperson of the Bylaws Committee. The committee members include the current and immediate past president of the medical staff, and the remainder of the Bylaws Committee should be current or past member of the Bylaws Committee, or have similar experience in order to maintain a high level of experience and continuity in oversight of the bylaws process. Members serve 3-year terms on the committee, and may serve 3 consecutive terms on the committee. The bylaws and rules and regulations are reviewed annually and any material changes to the bylaws or rules and regulations are submitted to the Medical Executive Committee for review and comment only after review and recommendation by independent outside counsel to the organized medical staff. The Bylaws Committee will meet as often as necessary at the call of its chair, but at least semi-annually. A record of its proceedings and action are maintained by the Medical Staff Office and reported to the MEC.

#### SECTION 7. PERFORMANCE IMPROVEMENT COMMITTEES

The medical staff shall participate in quality improvement activities of the hospital.

The Clinical Management Committee assists in performance improvement functions by providing a forum for collaboration between the medical staff and hospital operational leaders to review and improve system processes that affect the quality of patient care. The Committees meets at least bimonthly. A record of their proceedings and actions will be maintained by the medical staff offices and reported to the Medical Executive Committee.

## SECTION 8. PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee – this is a joint committee of St. Luke’s Hospital and Mercy Medical Center. The committee consists of representatives from each hospital pharmacy. Other members include 4 members of the active medical staff. The Committee meets at least bimonthly to review hospital formulary issues and all medication-related concerns, especially related to safe and appropriate use of medications. Medication safety concerns are reviewed and recommendations for system improvements are made. A permanent record of its proceedings and actions is maintained by the medical staff offices and reported to the Medical Executive Committee.

## SECTION 9 – CONFLICT RESOLUTION COMMITTEE –

Is established to discuss disagreements or controversies between the members of the medical staff and medical staff leaders, and between the medical staff and administration. The committee will provide a forum for discussing issues of interest, or where the bylaws are silent as to the process for evaluation and resolution of medical staff issues. This includes:

- a. Resolving Conflicts between the medical staff and Administration or Governing Body –
- b. Resolving conflicts between the medical staff and the MEC – except for actions involving peer review any action or recommendation of the MEC may be overturned by a majority vote of the eligible voting members of the Medical Staff through the following procedure:
  - i. Any eligible voting member of the Medical Staff may request a vote to overturn actions or recommendations of the MEC. Any such request will be made in writing to the MEC no later than 180 days from the MEC action that is the subject of controversy.
  - ii. The request to vote to overturn an MEC action must be approved by either a majority vote of the eligible voting Medical Staff members present at any regular or special meeting where a quorum is present as defined by these bylaws, or by a petition signed by at least 30% of the voting Medical Staff.
  - iii. If the request is approved, a vote to overturn the disputed MEC action will occur, and may be undertaken at any regular or special meeting of the Medical Staff.
  - iv. At least 15 days before any such meeting to overturn a MEC action, all eligible voting members of the Medical Staff will be given written notice of the meeting which will include the time and place of the meeting, and will include a written absentee ballot

by double envelope system or provide a secure anonymous electronic means for voting.

- v. All voting will be either in person at the time of the meeting, or by delivering the signed written absentee ballot or secure anonymous electronic absentee ballot to the Medical Staff office prior to the meeting.
- vi. A vote to overturn the MEC action will require the affirmative vote to overturn by a simple majority of the eligible voting Medical Staff where there is a quorum as defined by these bylaws.

## **ARTICLE XI - MEETINGS**

### **SECTION 1. MEDICAL STAFF MEETINGS**

- a. Annual Meeting - The annual staff meeting will be held in December of each year. At this meeting the retiring officers will make such reports as deemed necessary; the officers for the ensuing year will be elected.
- b. Regular Meetings - The Medical Executive Committee may provide for the holding of regular meetings of the Medical Staff by resolution, for the purpose of transacting such business as may come before the meeting. All regular meetings of the Medical Staff will be held at such day and hour as designated by the President in the call for such meeting. All members will be notified at least 3 weeks in advance of scheduled regular meetings of the medical staff.
- c. Special Meetings – may be called at any time for the purpose of addressing issues of interest to the medical staff, including but not limited to removal of officers, addressing controversies within the medical staff, or addressing disputes between the medical staff and administration. Special meetings may be requested by:
  - i. The President or the Medical Executive Committee may call a special meeting of the Medical Staff at any time. The president will, within seven days, issue a call for a special meeting after receipt of a written request for same, signed by not less than one-fourth of the active staff and stating the purpose of such meeting. The Medical Executive Committee will designate the time and place of any special meeting. Written or printed notice stating the place, day, and hour of any special meeting of the medical staff will be delivered, either personally or by U.S. mail, to each member of the active staff not less than two and not more than fourteen (14) days before the date of such meeting, by or at the direction of the president (or other persons authorized to call the meeting). If mailed, the notice of the meeting will be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. The attendance of a member of the medical staff at a meeting will constitute a waiver of notice of such meeting. No business will be transacted at any special meeting except that stated in the notice calling said meeting.
  - ii. Upon receipt of a written request presented to the President of Medical Staff signed by at least 30% of the medical staff eligible to vote.

The MEC shall notify ...

- d. Executive Session - At the call of the President of the Medical Staff or on motion and vote of the staff as a whole, the Medical Staff may meet in executive session, with attendance restricted only to active medical staff members, a recording secretary (who may be a medical staff member), and such advisors or other attendees as the President or Medical Staff may specifically request to attend.

- e. Quorum and Action

No formal action may be taken by the medical staff at any annual, regular or special meeting unless a quorum is present. Unless otherwise specifically stated, a quorum requires the presence of at least 30% of all voting members of the organized medical staff who must be present in person or by proxy. Written proxy statements at least 15 days prior to any regular or special meeting will be sent out with notice of the meeting and will include the matters to be voted upon at the meeting. A written ballot must be signed and delivered to the President of the Medical Staff or the Medical Staff Office prior to or at the meeting. All written ballots must be counted at the time of the regular meeting. Formal action may only be taken on the affirmative vote of a majority of voting members present when there is a quorum. Where a quorum is not reached, a special meeting of the Medical Staff will be called for the purpose of achieving a valid quorum in order to affect timely decision making.

- f. Procedural Rules

Every meeting of the Medical Staff will be conducted according to the then-current edition of Robert's Rules of Order. In the event of conflict between said Rules and any provisions of these bylaws, the bylaws will supersede said Rules. However, technical or not-substantive departures from those Rules will not invalidate an action taken.

## SECTION 2. CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

- a. Regular Meetings

Committees may, by resolution, provide for a time and place of holding regular meetings without any formal notice other than such resolution. Departments will hold regular meetings in accordance with departmental policy to review and evaluate the clinical work of practitioners with privileges in the department.

- b. Special Meetings

- i. A special meeting of any committee or department may be called by or at the request of the chairman, by the President of the Medical Staff, or at the request of one-third of the department or committee members, but not less than two members.
- ii. Written or oral notice stating the place, day, and hour of any special meeting, or of any regular meeting not held pursuant to resolution, will be given to each member of the committee or department, not less than five business days before the time of such meeting by the person or persons calling the meeting. If mailed, the notice of the meeting will be deposited, postage prepaid, in the United States mail at least seven business days before the meeting, addressed to the member at his/her address as it appears on the records of the hospital. The attendance of a member at a meeting will constitute a waiver of notice of such meeting.

- c. Quorum - A quorum is present when there is thirty percent (30%) of eligible voting members of the medical staff. For committees or clinical departments, a quorum requires at least two voting members be present to conduct business.
- d. Executive Session - At the call of its chairman, any medical staff committee or department, may meet in executive session, with attendance restricted to medical staff members, a recording secretary (who may be a medical staff member), and such advisors or other attendees as the chairman may specifically request to attend.
- e. Ex-officio committee members – Unless otherwise provided under these bylaws, ex-officio members do not have the right to vote or be counted toward a quorum, and participate at the will of the department chairperson or designee.

### **SECTION 3. MANNER OF ACTION**

Unless as otherwise specified in these bylaws, the action of a majority of the members present in person or by proxy at a meeting in which a quorum is present will be the action of the committee or department. Action may be taken without a meeting by unanimous written consent signed by each member entitled to vote on the matter.

### **SECTION 4. MINUTES**

Minutes of each regular and special meeting of a committee or department will be prepared and will include a written record of the attendance of members and any vote taken on department or committee business. The minutes will be signed by the presiding officer and copies thereof will be promptly submitted to the attendees for approval, and after such approval is obtained, forwarded to the Medical Executive Committee. Each committee and department will maintain a permanent file of the minutes of each meeting.

## **ARTICLE XII Rules and Regulations**

Core Principle - The rules, regulations and policies of the medical staff may not conflict with the medical staff bylaws. Where there is an apparent conflict with the bylaws, the bylaws will in every case be controlling. All proposals to alter, amend or impact on the rights, duties and obligations of the medical staff will be reviewed by independent medical staff counsel prior to recommending any such changes.

General Principles - The organized medical staff will adopt such rules and regulations as may be necessary to implement the principles embodied within these bylaws. The rules and regulations will relate to the organization and function of the organized medical staff and are a part of the medical staff bylaws. Rules and regulations may be amended or repealed by a majority vote of all voting members physically present or voting by written ballot or proxy at any regular meeting in which a quorum is present, and notice is given to all voting members of the organized medical staff. All written ballots must be counted at the time of the regular meeting. Any such change will become effective when approved by the governing body. The Rules and Regulations will be reviewed by the Bylaws Committee and the Board on an annual basis.

The authority to amend rules, regulations and policies – The medical staff delegates to the MEC the responsibility for making non-substantive changes to rules, regulations and policies. The medical staff does

not delegate authority to the MEC or other decision making body to amend or alter the following core medical staff functions, including but not limited to:

- i. Medical staff rights and responsibilities
- ii. Privileging and credentialing functions
- iii. Hearing and Appeal rights
- iv. Focused practice review
- v. Peer review activities
- vi. Any activity that could result in the loss of membership status, or any change in member privileges
- vii. Emergency Call coverage
- viii. Department function and decision making
- ix. Quorum requirements
- x. Categories of medical staff membership or status
- xi. Amending or approving the bylaws
- xii. Conflict of Interest requirements

### **ARTICLE XIII Allied Health Professionals**

- a. Allied health practitioners (AHPs) – are licensed non-physician health professionals granted dependent or independent practitioner status under State Scope of Practice rules and regulations. Whether employed by the hospital or affiliated with an active member of the medical staff, AHP’s are not members of the medical staff, but as non-physician practitioners granted privileges under these bylaws, are subject to the medical staff bylaws, rules, regulations, and policies. While an AHP may be granted independent practitioner status under state scope of practice rules or regulations, ALL non-physician practitioners will be assigned to a specific clinical department and are subject to supervision and oversight by a named active member of the appropriate clinical department.
- b. AHP Supervision requirement - All AHPs having a supervising physician who is a member of the active medical staff with admitting and H&P privileges, and is granted specific supervisory privileges through the medical staff privileging process. The supervising member must, at all times hold unrestricted clinical privileges for all privileges requested by, and granted to the AHP. Any change in the supervising physician’s privileges that result in an inability to supervise each and every privilege held by the AHP will require an immediate, automatic suspension of clinical privileges under these bylaws, and may require a new supervising physician.
- c. Loss Supervising Physician – A failure to obtain, or maintain a supervising physician results in an automatic suspension of all clinical privileges within the hospital. In this setting the affected AHP MUST obtain an alternative affiliation with an appropriately privileged member of the relevant clinical department within 60 days. An AHP who is unable to obtain an appropriately credentialed supervising physician agreement, automatically forfeits all clinical privileges within the hospital. Any such administrative loss of clinical privileges does not invoke the right to a fair hearing and appeals under these bylaws and is not reportable to the NPDB.
- d. AHP Privileging – All AHP’s are privileged through the medical staff privileging process. A supervising physician must be granted specific supervisory privileges through the medical staff privileging process prior to assuming supervision of an AHP. All AHP’s are supervised by an active member of the medical staff who holds specific supervisory privileges and is granted specific clinical privileges that correspond to all clinical privileges requested by, and granted to the AHP. All AHP requests for initial or additional clinical privileges are submitted in writing through the supervising physician to the appropriate

department chair who will review all information, and make a subsequent recommendation to the Credentials Committee. The CC will review all such requests, and forward its recommendation to the MEC, who will, in turn provide a recommendation to the governing body to grant, reject, or defer a decision on the request.

- e. AHP Focused Practice Evaluation -All AHP granted initial privileges or requesting additional privileges are subject to focused review. The focused review will be jointly performed by the supervising physician and the clinical department chair, and completed within the first 6 months after granting clinical privileges to the AHP. If the focused review is not completed within one year, there will be an *AUTOMATIC SUSPENSION* of clinical privileges, which is non-reportable and does not invoke automatic hearing and appeals rights under these bylaws. for the affected AHP.

#### **ARTICLE XIV** ***AHP HEARING AND APPEAL PROCESS***

Whenever the Medical Executive Committee, other decision making body, or the Board make a recommendation or take actions to restrict or deny an allied health professional's delegated activities, the allied health professional has a right to a fair hearing.

- a. Whenever the Medical Executive Committee or the Board make a recommendation or takes an action to deny an allied health professional's membership or delegated Activities, or to restrict any or all delegated activities for more than 30 days, the Administrative Medical Director, or designee, will provide the allied health professional special written notice containing the following items:
  - recommendation or action from the Medical Executive Committee or the Board;
  - the reasons for it;
  - and a deadline of thirty (30) days within which the allied health professional can request a hearing
- b. When the allied health professional is employed by the hospital, the supervising nursing director and the medical director of the service line will be notified in writing.
- c. An allied health professional who fails to request a hearing automatically waives the right to review. The practitioner will be notified by special written notice that the recommended actions will be forwarded to the Hospital Board of Directors for final recommendation.
- d. If a hearing is requested by the allied health professional, the Administrative Medical Director, or Designee, appoints a hearing committee comprised of two (2) voting members of the medical staff, and one (1) allied health professional, with clinical privileges consistent with the bylaws conflict of interest policy, to hear the allied health professional's objections to the proposed action or recommendation.
- e. The hearing will be scheduled within thirty (30) days from the date of the hearing request by the allied health professional.

- f. The hearing notification will be sent by special written notice to the allied health professional and his/her supervising physician.
- g. An official transcript will be made of the hearing. The hearing committee will provide a written report of its recommendations and the reasons therefor, based on the information presented at the hearing. The Administrative Medical Director, or Designee, will send the report to the affected practitioner and his/her supervising physician, by special written notice within 5 business days and will also promptly notify the Medical Executive Committee, and the Board or Board Committee of its findings and recommendations.
- h. The allied health professional and/or the Medical Executive Committee may appeal the hearing committee's recommendation by submitting a written statement of the reasons for the appeal to the Board or Board Committee, within 30 days of receiving the hearing committee's report.
- i. The Board, or a Board Committee, may review the written appeal, and the Hearing Committee's report. Upon receiving the written request for appeal the Board may as a body review the request for appeal or appoint a committee representing the Board to review the request.
- j. If the appeal is reviewed by a Board Committee, it will promptly provide the parties and the Board with its written recommendation within five (5) business days after the conclusion of the review.
- k. The Board will provide all parties with a written report of their final decision, and the reason therefor in special written notification within five (5) days of their decision.
- l. Final actions regarding the allied health professional will be reported to the National Practitioner Data Bank, if required.

## **ARTICLE XV Amendments**

These bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the medical staff. A proposed amendment will be referred to the Bylaws Committee which will report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment will require a secret ballot using a two-envelope system, and require an affirmative two-thirds vote of the active medical staff submitting ballots where a quorum is present as defined by these bylaws. Amendments so made will be effective when approved by the Board. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations and the board shall not unreasonably withhold approval of amendments following this process.

## **ARTICLE XVI IMMUNITY FROM LIABILITY**

All membership and clinical privileges applications, will state the following as a required condition for membership and/or clinical privileges:

- a. That any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of any authorized representative of this or any other health care facility for the purpose of achieving and maintaining quality patient care in this or any other health care facility, will be privileged to the fullest extent permitted by law.
- b. That such privilege will extend to any members of the hospital's Medical Staff and of its Board, its other practitioners, CEO, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XII, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the medical staff.
- c. There will be, to the fullest extent permitted by law, immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure by any person or body listed in this Article, even where the information involved would otherwise be deemed privileged.
- d. That such immunity will apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:
  - i. applications for appointment or clinical privileges;
  - ii. periodic reappraisals for reappointment or clinical privileges;
  - iii. corrective action, including summary suspension;
  - iv. hearings and appellate reviews;
  - v. medical care evaluations;
  - vi. utilization reviews; and
  - vii. other hospital, department, section, or committee activities related to quality patient care and inter professional conduct and peer review activities.
- e. That the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to a practitioner's professional qualifications, clinical competency, character, mental or physical condition, ethics, or any other matter that might have an effect on patient care.
- f. That in furtherance of the foregoing, each practitioner will, upon request of the hospital, execute releases in accordance with these bylaws in favor of the individuals and organizations specified in paragraph b, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.
- g. That the consent, authorizations, releases, rights, privileges, and immunities provided by these bylaws for the protection of this hospital's practitioners, other appropriate hospital officials, personnel, and third parties, in connection with applications for initial appointment and for reappointment, will also be fully applicable to the activities and procedures covered by this Article.
- h. The Hospital will defend, indemnify, and hold all Medical Staff officers, department chairs, committee chairs, committee members and other participating medical staff members harmless for good faith actions taken when acting in the course and scope of their official Medical Staff duties and responsibilities.

- g. The bylaws remain a binding mutual exchange of promises between the medical staff and the hospital. The immunity provisions in the bylaws do not affect the enforceability of the bylaws. Should the immunity provisions be interpreted by a court of jurisdiction in Iowa or in a federal court where immunity language could undermine the enforceability of these bylaws, then the immunity provisions will be enforced only to the extent that will provide immunity to the extent allowed by law, that will not invalidate any portion of these bylaws. Any provisions of these bylaws that would invalidate the enforceable nature of this agreement will be severed from the bylaws.

**ADOPTED BY ST. LUKE'S ACTIVE MEDICAL STAFF  
\_\_\_\_, 2012**

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**President of the Medical Staff**

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**Secretary of the Medical Staff**

**APPROVED BY ST. LUKE'S BOARD OF DIRECTORS  
\_\_\_\_, 2012**

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**Secretary of the Board of Directors**