1. ARTICLE ONE: DEFINITIONS/CONSTRUCTION OF TERMS AND HEADINGS

1.1. DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Administration: The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO), and Chief Medical Officer (CMO).

Administrator: The individual appointed by Corporate Management to act on behalf of the Hospital in the overall management of the Hospital. The administrator holds the title of Chief Executive Officer (CEO) of the Hospital. In the event of his/her absence, the CEO may select a designee to temporarily serve in the role of administrator.

Adverse Action: An action that adversely affects an individual’s Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these Bylaws. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.

Advanced Practice Professional (APP): An individual, other than those defined under “Practitioner,” who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. APPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. APPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), and advanced registered nurse practitioners (ARNP). Other categories approved by the Board for clinical privileges without membership are: certified nurse midwives (CNM), clinical psychologists (Ph.D.) and Social Workers.

Applicant: An individual who has submitted a complete application for appointment, reappointment of clinical privileges.

Board Certification: A designation for a physician or other practitioner who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty. Board certification shall be from an American Board of Medical Specialties (ABMS) Member Board or from a Member Board of Certification of the Bureau of Osteopathic Specialists or from the American Board of Podiatric Surgery (ABPS) if the applicant is a podiatrist, or from the American Board of Oral/Maxillofacial Surgeons (ABOMS) if the applicant is an oral surgeon. ABMS is the umbrella organization for the 24 approved medical specialty boards in the United States. Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements. The Bureau of Osteopathic Specialists was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. There are currently 18 AOA certifying boards. Each is titled, "American Osteopathic Board of (Specialty).” Podiatrists are certified through the American Board of Podiatric Surgery (ABPS) and oral surgeons are certified through the American Board of Oral/Maxillofacial Surgeons (ABOMS).

1 42 C.F.R. §482.12(a)(1)
Board of Directors: The individuals elected by the shareholders for the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital and are the governing body of the Corporation (or Partnership), sometimes herein referred to as the “Directors.”

Board of Trustees: As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. It is the “governing body” as described in the standards of the Joint Commission and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the “Trustees” or the “Board” unless otherwise specifically stated.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

Certification: The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.  

President of the Medical Staff: A Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital. The President of the Medical Staff shall be a doctor of medicine or osteopathy.

Clinical Privilege/Privilege: The permission granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, psychiatric, dental, or podiatric services with the approval of the Board.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant. Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Contract Practitioner: A Practitioner providing care or services to Hospital patients through a contract or other arrangement.

Corporation (or Partnership): The legal owner of the Hospital.

CPCS: The Clinical Patient Care System, used to electronically document patient care.

Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or misdemeanor including but not limited to (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA.

Days: Calendar days, unless otherwise noted.

---

2 42 C.F.R. §482.12
3 HCA, Ethics & Compliance Policy QM.002
4 LD.01.05.01; 42 C.F.R. §482.22(b)(3)
5 MS.06.01.03, MS.06.01.07, MS.08.01.03
**Dentist:** An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree from a dentistry program accredited by the Commission on Dental Accreditation (CODA) and has a current, unrestricted license to practice dentistry.

**Dependent Healthcare Professional:** An individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual’s license and in accordance with a Hospital-approved scope of practice.⁶

**Department:** A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

**Disruptive Conduct:** Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a “hostile work environment” for hospital employees or other individuals working in the Hospital, or begins to interfere with the disruptive individual’s own ability to practice competently. Such conduct may include rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

**Division:** A clinical subgrouping of members of a Medical Staff Department in accordance with their subspecialty or specialized practice interest, as specified in these Bylaws.

**Encounter/Patient Encounter:** Any face to face interaction with a patient; or any physician order that involves the hospital providing services to a patient, excluding diagnostic testing.

**Executive Committee/Medical Executive Committee (MEC):** The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

**Ex Officio:** Serves as a Member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

**Fair Hearing Plan:** The fair hearing plan as approved by the Medical Executive Committee and Board and incorporated into these Bylaws.

**Federal Health Care Program:** Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program).⁷ The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.⁸

**Good Standing:** The term “good standing” means a staff Member who, during the current term of appointment, has maintained qualifications for Medical Staff membership and assigned staff category, has met attendance and participation requirements, is not in arrears in dues payment or the completion of medical records, and has not received a suspension or restriction of membership or privileges.

**Governing Body:** The Board of Trustees of the Hospital, which has been delegated specific authority and responsibility, and appointed by the Board of Directors.

---

⁶ HCA, Ethics & Compliance Policy QM.002; 42 C.F.R. §482.12(c)(2)
⁷ Section 1128B(f) of the Social Security Act
⁸ HCA, Ethics & Compliance Policy QM.002
GSA List: The General Service Administration’s List of Parties Excluded from Federal Programs.9


Healthcare Professional: An individual licensed, certified, or registered by the State, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health, to provide health care to patients.

Hospital: Tallahassee Medical Center, Inc., 2626 Capital Medical Boulevard, Tallahassee, FL 32308, d/b/a “Capital Regional Medical Center”. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

Independent Healthcare Professional: An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual’s license and in accordance with individually granted clinical privileges.10

Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.11

License: An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.12

License Status: Indicates the status of the practitioner’s license, which is issued by the State licensure board. The categories defined by the State board are:13
• active—full and unrestricted license to practice
• inactive—practitioner is not practicing, but reserves the right to activate their license in the future
• expired—no longer valid for use
• revoked—disciplinary action prohibits practice
• restricted—board imposed limitation on practice
• suspended—board imposed disciplinary action prohibiting practitioner from practicing for a specified period of time.

Licensure: A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.14

Licensed Independent Practitioner (LIP): An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual’s license and in accordance with individually granted clinical privileges. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the

---

9 HCA, Ethics & Compliance Policy QM.002
10 HCA, Ethics & Compliance Policy QM.002; 42 C.F.R. §482.12(c)(1); 42 C.F.R. §482.12(c)(4)
11 HCA, Ethics & Compliance Policy QM.002
12 HCA, Ethics & Compliance Policy QM.002
14 HCA, Ethics & Compliance Policy QM.002
categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).\textsuperscript{15}

**Medical Staff:** The Medical Staff is the term referring to the Practitioners designated by the Board to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM). The Medical Staff is an integral part of the Hospital and is not a separate legal entity.\textsuperscript{16}

**Medical Staff Office:** The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Office responsibilities are assigned by Administration and the Hospital employee(s) who work in the Medical Staff Office is accountable to Administration. The documents maintained by the Medical Staff Office are the property of the Hospital.

**Medical Staff, Organized:** The Organized Medical Staff is the body of those individuals who, as a group, are responsible for establishing the Bylaws and Rules and Regulations, and policies for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members. The Organized Medical Staff is limited to Practitioners who are Medical Staff members in the Active category of membership and have therefore been granted the rights to vote, to be a member of a Medical Staff committee, and to hold office in the Organized Medical Staff.

**Medical Staff Year:** The period from January 1 to December 31 of each year.

**Medico-Administrative Practitioner:** A Practitioner who is under contract, employed by, or otherwise engaged by the Hospital on a full time or part time basis, whose responsibilities may be both administrative and, if permitted by State law, clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner’s direction.

**Member:** A Practitioner who has been granted and maintains Medical Staff membership and whose membership is in good standing pursuant to these Bylaws.

**Membership:** The approval granted by the Board to a qualified Practitioner to be a Member of the Medical Staff of the Hospital.

**Non-Privileged Practitioner:** Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.\textsuperscript{17}

**OIG Sanction Report:** The HHS/OIG List of Excluded Individuals/Entities.\textsuperscript{18}

**Oral and Maxillofacial Surgeon Qualified:** An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).\textsuperscript{19}

**Peer:** An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.\textsuperscript{20}

\textsuperscript{15} 42 C.F.R. §482.12(a)(1); 42 C.F.R. §482.12(c)(1)
\textsuperscript{16} 42 C.F.R. §482.12(a)(1)
\textsuperscript{17} HCA, Ethics & Compliance Policy QM.002
\textsuperscript{18} HCA, Ethics & Compliance Policy QM.002
\textsuperscript{19} Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH), Glossary
\textsuperscript{20} MS.07.01.03
**Peer Review:** The concurrent or retrospective review of an individual’s performance of clinical professional activities by peer(s) through formally adopted written procedures that provide for adequate notice and an opportunity for a hearing of the Healthcare Professional under review. With reference to Practitioners and Allied Health Professionals, written procedures for peer review are part of these Bylaws.

**Proctor/Proctoring:** Clinical proctoring is an objective evaluation of a Practitioner’s actual clinical competence by a monitor or proctor who represents the Medical Staff and provides for adequate notice and an opportunity for a hearing of the Healthcare Professional under review. With reference to Practitioners and Advanced Practice Professionals, written procedures for peer review are part of these Bylaws.

**Physician:** An individual who has been educated and trained in the practice of medicine, and who holds a current license as a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

**Podiatrist:** An individual who holds a current license as a Doctor of Podiatric Medicine (DPM).

**Practitioner/Licensed Independent Practitioner (LIP):** Individuals who provide direct patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).21

**Privileges:** Authorization granted by the Board to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual’s license, education, training, experience, competence, health status, judgment and individual character.22 Privileges shall be setting-specific, meaning that the privileges granted shall be based not only on the applicant’s qualifications, but also a consideration of the Hospital’s capacity and capability to deliver care, treatment, and services within a specified setting.23

**Qualified Medical Person or Personnel:** In addition to a physician, Qualified Medical Persons may perform a Medical Screening Examination. Individuals in the following professional categories who have demonstrated current competence in the performance of Medical Screening Examinations, and who are functioning within the scope of his or her license and policies of the Hospital, have been approved by the Board as Qualified Medical Personnel: Registered Nurse in Perinatal Services, Psychiatric Social Worker, Registered Nurse responsible to the Medical Staff, Emergency Medicine Nurse Practitioner, and Emergency Medicine Physician Assistant.

**Qualified Physician:** A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the Hospital to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.24

**Registration:** The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.25

**Rules and Regulations:** The Rules and Regulations of the Medical Staff including those of its Departments and Divisions as approved by the Medical Executive Committee and Board of Trustees.

---

21 42 C.F.R. §482.12(a)(1); 42 C.F.R. §482.12(c)(1)
22 42 C.F.R. §482.12(a)(6); MS.06.01.07
23 MS.06.01.07
24 Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH), Glossary
25 HCA, Ethics & Compliance Policy QM.002
**Staff:** Unless otherwise specifically stated, the Medical Staff of this Hospital.

**State:** The State in which the Hospital operates and is licensed to provide patient care services, which is Florida.

**Telemedicine:** Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. The Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.

1.2 **CONSTRUCTION OF TERMS AND HEADINGS**

All pronouns and any variations thereof in these Bylaws and Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

2. **ARTICLE TWO: NAME, PURPOSES & RESPONSIBILITIES**

2.1. **NAME**

The name of the Medical Staff shall be the “Medical Staff of Capital Regional Medical Center.”

2.2. **ESTABLISHMENT OF MEDICAL STAFF**

There shall be established within Capital Regional Medical Center a Medical Staff, which shall consist of all physicians, dentists, podiatrists and other categories of Licensed Independent Practitioners who have been deemed eligible to apply for Medical Staff membership or clinical privileges within Capital Regional Medical Center. No Practitioner shall admit or provide medical or health-related services to any patient in Capital Regional Medical Center unless he or she has been granted clinical privileges, including temporary privileges. The Board of Trustees shall, in the exercise of its discretion, delegate to the Medical Staff the responsibility for providing appropriate professional care to Capital Regional Medical Center patients. The Medical Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital and shall report such activities and their results to the Board of Trustees.

2.3. **PURPOSES AND RESPONSIBILITIES**

The purposes and responsibilities of the Medical Staff are:

2.3.1. To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide

---

26 Definition of the Federation of State Medical Boards
27 MS.13.01.01– MS.13.01.03
28 Joint Commission Comprehensive Accreditation Manual for Hospitals
mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and functions of the Medical Staff.\(^{30}\)

2.3.2. To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;

2.3.3. To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital.\(^{31}\)

2.3.4. To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance.\(^{32}\)

2.3.5. To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals.

2.3.6. To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;

2.3.7. To adopt Rules and Regulations for the proper functioning of the Staff, and the integration and coordination of the Staff with the functions of the Hospital;

2.3.8. To provide a means for communication and conflict resolution with regard to issues of mutual concern to the Staff, Administration, and Board;\(^{33}\)

2.3.9. To participate in identifying community health needs and establishing appropriate institutional goals;\(^{34}\)

2.3.10. To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review.\(^{35}\)

2.3.11. To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted.

2.3.12. To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies;

2.3.13. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.\(^{36}\)

\(^{30}\) MS.01.01.01; LD.01.05.01, 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3), 42 C.F.R. §482.12(a)(3)
\(^{31}\) LD.04.03.07
\(^{32}\) MS.01.01.01; LD.01.05.01, 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3)
\(^{33}\) MS.01.01.01, MS.03.01.03, MS.04.01.01; LD.03.04.01
\(^{34}\) LD.02.01.01, LD.04.03.01; LD.04.03.01
\(^{35}\) 42 C.F.R. §482.12(a)(5), MS.05.01.01, MS.08.01.01; MS.08.01.03; MS.09.01.01
\(^{36}\) LD.04.01.01; 42 C.F.R. §482.11(a)
2.4. POWERS AND RESPONSIBILITIES OF THE BOARD OF TRUSTEES

2.4.1. The Hospital is owned by the Corporation. The Corporation retains all authority and control over the business, policies, operations, and assets of the Hospital via the Board of Directors. The Board of Directors is elected by the shareholders of the Corporation. The Board of Directors retains ultimate responsibility for the Hospital’s compliance with all applicable Federal, State, and local laws and regulations. The Board of Directors has delegated certain duties to the Corporation’s officers and to the Board of Trustees. The rights and duties delegated to the Board of Trustees, acting in its capacity as the authorized agent of the Corporation, and the governing body of the Hospital are described in these Bylaws.

2.4.2. The Board of Directors has appointed the Board of Trustees to assist and advise the CEO, the Corporation, the Board of Directors, and the Medical Staff. The primary function of the Board of Trustees shall be to assure that the Hospital and its Medical Staff provide quality medical care that meets the needs of the community. For this purpose, the Board of Directors has delegated to the Board of Trustees the authority to receive and evaluate periodic reports from the Medical Staff and its officers, to make decisions in compliance with the Corporation’s policies regarding Medical Staff appointments, reappointments, and the granting of clinical privileges, to oversee performance improvement, utilization review, risk management, and similar matters regarding the provision of quality patient care at the Hospital, and to establish policies regarding such matters. All officers, Medical Staff members, advanced practice professionals, employees, non-employees who provide patient care under an approved scope of practice, and other agents of the Hospital are subject to the control, direction and removal by the Board of Trustees. All Practitioners are subject to appointment, termination or modification of their Medical Staff Membership and/or clinical privileges by the Board of Trustees, based on factors deemed relevant by the Board of Trustees. Actions taken by the Board of Trustees may, but need not, follow the procedures outlined in the Medical Staff Bylaws and related documents.

2.4.3. In a manner mutually agreeable to the Corporation and the Board of Trustees, the Board of Trustees shall report any matters of concern to the Corporation. Any such matters that are within the scope of duties of the Board of Trustees, but exceed the scope of their authority, such as issues related to financial management, can be referred back to the Corporation and the Board of Directors.

2.4.4. The Board of Directors, through its officers and the CEO, retains authority for the Hospital’s business decisions, adherence to HCA Ethics & Compliance Policies, and financial management, including long-range and short-range planning and budgeting, but may request the advice of the Board of Trustees on such matters. The Board of Directors expressly reserves the right to amend, modify, rescind, clarify, or terminate at any time and without notice any delegation of authority given to the Board of Trustees and, if deemed necessary by the Board of Directors, to overrule decisions made by the Board of Trustees.

---

37 42 C.F.R. §482.11; 42 C.F.R. §482.12; The Joint Commission Standard, LD.04.01.01
38 The Joint Commission Standard, LD.01.01.01
39 The Joint Commission Standard, LD.01.03.01
40 The Joint Commission Standard, LD.01.03.01; 42 C.F.R. §482.12(a)
42 The Joint Commission Standard, LD.01.03.01
2.5. **NATURE OF APPOINTMENT**

No Practitioner shall admit or provide medical or health-related services to patients in the Hospital unless he or she has been appointed to the Medical Staff or has been granted clinical privileges, or temporary privileges pursuant to these Bylaws. Appointment to the Medical Staff shall confer upon the Medical Staff member a privilege in the nature of a license to exercise only such clinical privileges within the Hospital as are specifically granted by the Board of Trustees in accordance with these Medical Staff Bylaws. The requirements and procedures for appointment and reappointment to the Medical Staff and granting of clinical privileges are set forth in these Bylaws. A Medical Staff appointee or Practitioner with clinical privileges is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Medical Staff member or Practitioner with clinical privileges. In the event of any conflict between the language of these Medical Staff Bylaws, Medical Staff Rules & Regulations, or Medical Staff policies and a specific contract between the Hospital and a Medical Staff member or Practitioner with clinical privileges, the language of the contract shall control. 43

2.6. **ORGANIZED HEALTH CARE ARRANGEMENT: HIPAA COMPLIANCE**

Organized Health Care Arrangement; HIPAA Compliance. The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital’s Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the Hospital to share information with the Physicians and the Physicians’ offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital’s registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Physicians, Advanced Practice Professionals with clinical privileges or practice prerogatives and non-employees who provide patient care under an approved scope of practice. Each Medical Staff member, each Physician with temporary privileges, Advanced Practice Professional with clinical privileges or practice prerogatives and non-employee with an approved scope of practice agrees to comply with the Hospital’s policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI"). 44

3. **ARTICLE THREE: APPOINTMENT/REAPPOINTMENT**

3.1. **NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS**

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care independently within the Hospital, and whom the Board appoints. 45 Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws.

---


44 45 C.F.R. §164.501

45 MS.01.01.01; LD.01.05.01, 42 C.F.R. §482.22(a)
3.1.1. Patients may be admitted to the Hospital only on the orders of a physician (MD/DO). All Hospital patients must be under the care of a Member of the Medical Staff or under the care of a practitioner who shall be directly under the supervision of a Member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges.  

3.1.2. Patients admitted by licensed independent practitioners who are not physicians, dentists, oral/maxillofacial surgeons, podiatrists, shall be under the care of a physician with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner.

Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual’s Staff category or as are afforded to APPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws “membership in” is used synonymously with “appointment to” the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws. The Hospital-specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws, and has been approved and implemented by the Medical Staff and the Board. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations.

3.2. THRESHOLD ELIGIBILITY CRITERIA

To be eligible to apply for initial appointment or reappointment to the medical staff, or to apply for clinical privileges, a practitioner must be a physician, dentist or oromaxillofacial surgeon, podiatrist, clinical psychologist, advanced practice registered nurse, midwife, physician assistant, or social worker and meet the following criteria:

3.2.1. IDENTITY

Have proof of identity and either US citizenship or evidence of status as a lawful permanent resident of the U.S., and provide a copy of a current government-issue photo ID.

3.2.2. LICENSURE

Have a current, unlimited, unrestricted (not applicable to Practitioners on the Medical Staff with privileges in good standing at the time of this Bylaws revision – September 24, 2013), active (as defined in these Bylaws) legal license to practice in his or her respective profession in the State of Florida, which license permits him or her to practice in the Hospital setting and authorizes him or her to receive and examine patients, diagnose conditions and prescribe and implement a treatment plan and to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner’s area of practice, independent of review, and supervision or prescription by another Practitioner.

---

46 42 C.F.R. §482.12(a)(5), Interpretive Guidelines
47 42 C.F.R. §482.12(c)(4); MS.03.01.03
48 42 C.F.R. §482.12(a)(1)
49 MS.01.01.01
50 MS.01.01.01
51 MS.01.01.01, MS.01.01.03, MS.06.01.07, MS.08.01.03
or in the case of an APP, to practice within the full scope of licensure with any supervision as may be required by law; 52 and,

3.2.2.1. If the applicant is an active duty military Practitioner, and will be practicing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then current, unlimited, unrestricted, active licensure from any State shall be accepted.

3.2.2.2. If the applicant is a telemedicine Practitioner located in a different State, the applicant must also possess current, unlimited, unrestricted, active licensure in that State.

3.2.2.3. If the applicant is an out-of-state Practitioner who will be providing patient care in this state under an exception to state licensure requirements, the exception must be verified with the State licensure board and documented. Any conditions associated with the exception (i.e., that the exception requires that the Practitioner must be licensed in his/her home State) must also be verified and documented. 53

3.2.3. CONTROLLED SUBSTANCE REGISTRATION

Where applicable to his or her practice, the practitioner must have a current, unrestricted Federal DEA registration valid for prescribing within the State of Florida with the applicant’s Florida in-state address and which permits him or her to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner’s area of practice, independent of review, supervision or prescription by another Practitioner. 54

3.2.4. PROFESSIONAL EDUCATION AND TRAINING

The applicant must have graduated from an accredited School of Medicine, Dentistry, Podiatry, or school appropriate to their profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) or an accredited Firth Pathway Program, and have verification of graduation from a foreign medical school. An applicant Practitioner must also have successfully completed a residency program in the field of specialty for which the Practitioner requests clinical privileges (refer to 3.9.2.10. for exception) and shall be board certified, board qualified as defined by the specialty board for his/her specialty, or comparably qualified as defined by the Medical Executive Committee. 55 At the time of reappointment to the Medical Staff or renewal or revision of clinical privileges, the applicant shall document his/her participation in continuing education as related to the clinical privileges requested. Participation in continuing education shall be considered when making decisions about clinical privileges. 56

3.2.5. CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

The applicant must document his/her current (i) background, experience, training, judgment and demonstrated clinical competence; (ii) adherence to the ethics of their profession; (iii) good reputation and character, including the applicant’s mental and emotional stability and physical health status, and (iv) ability to work harmoniously with others sufficiently, as determined at the discretion of the Medical Executive Committee

52 MS.06.01.07, 42 C.F.R. §482.11(c), 42 C.F.R. §482.22(c)(4)
53 HCA Ethics Policy, CSG.QS.002
54 21 U.S.C. §§ 823(f) and 824(a)(3)
55 MS.06.01.03, 42 C.F.R. §482.12(a)(6), 42 C.F.R. §482.22(c)(4)
56 MS.12.01.01
and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that the Hospital and its Medical Staff will be able to operate in an orderly manner. Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Department Chairperson(s).

3.2.6. BOARD CERTIFICATION

All initial physician applicants must be either Board Certified, Board Eligible or demonstrate that he or she has obtained the training requisite to board certification in the areas of proposed practice. Continued Medical Staff membership will require a physician who is Board Eligible to obtain board certification in the proposed area of practice within the board eligibility timeframe as defined by a hospital-recognized board. In the event the certification board has not defined an eligibility period, it shall be five (5) years from completion of training. Physicians must be board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (ABMS), or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, the board certification program accepted by the Hospital is the American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Medicine (ABPM), and for dentists and oromaxillofacial surgeons, the board certification program accepted by the Hospital is the American Board of Oral/Maxillofacial Surgeons (ABOMS) or the American Dental Association (ADA). If the applicable board eligibility requirements include the successful completion of a residency program, this residency program must be completed through an approved postgraduate training program (see exception 3.9.2.10.) In the event that the board eligibility requirements include a post-residency practice requirement, this requirement may be met at the Hospital, provided that all other requirements for Medical Staff membership are met. All initial other applicants must have successfully completed an approved post-graduate training program in their respective profession. Notwithstanding the foregoing, the Board shall have the power to waive the board certification requirement under extraordinary circumstances. There shall be documentation of the need for the talents of the applicant prepared by the Credentials Committee for review and recommendation by the Medical Executive Committee and for review and action by the Board. Extraordinary circumstances should be considered only if (i) the applicant has a current, unrestricted license as required by the State of Florida, (ii) the applicant is not an Ineligible Person, and (iii) the applicant has achieved extraordinary recognition in the field of medicine as related to the needed talents documented by the Credentials Committee. This rule shall not apply to members of the Medical Staff at the time of adoption by the Board of Trustees in October 2010.

3.2.7. CONDUCT/BEHAVIOR

The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a

57 MS.06.01.03, MS.06.01.07, 42 C.F.R. §482.12(a)(6)
review of conduct during the previous term(s) of appointment and recommendation(s) provided by Division and Department Chairperson(s).

3.2.8. PROFESSIONAL ETHICS AND CHARACTER
By virtue of applying for medical staff membership or clinical privileges, and agreeing to abide by the medical staff bylaws, the applicant shall be bound to adherence to the code of ethics of his/her professional discipline (e.g., the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant’s practice if it is not listed). The applicant shall also agree to abide by applicable provisions of the Code of Conduct of HCA, and the code of ethical business and professional behavior of this Hospital. 58

3.2.9. HEALTH STATUS/ABILITY TO PERFORM
The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental impairment that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the President of the Medical Staff. Upon receipt of such notification, the President of the Medical Staff will meet with the applicant to determine the extent of the impairment. If it is determined that the impairment does not adversely affect the applicant’s ability to perform the essential functions of the clinical privileges requested, the President of the Medical Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

3.2.10. INTERPERSONAL AND COMMUNICATION SKILLS
The applicant shall possess an ability to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients’ medical records, shall be documented in English.

3.2.11. PROFESSIONAL LIABILITY INSURANCE
The applicant shall maintain professional liability insurance coverage through an insurance carrier authorized by the State of Florida as a licensed provider of professional malpractice insurance, for the clinical privileges requested with limits of at least $250,000 for each claim and $750,000 in aggregate, as a qualification for initial appointment and to cover the term of the individual’s Medical Staff membership or clinical privileges (e.g., “claims-made” coverage). 59

Self Insured Coverage consists of either:

a) Establish and maintain an escrow account or irrevocable letter of credit in the minimum amount of $250,000 per occurrence and $750,000 in the aggregate; or completion of Florida Department of Health’s Financial Responsibility attestation form.

58 42 C.F.R. §482.12(a)(6); LD.02.02.01; LD.04.02.01; LD.04.02.03; LD.04.02.05; HCA, Ethics and Compliance Policies
59 HCII recommended insurance requirements
b) Request for being self-insured or a request for exemption from maintaining professional liability insurance coverage through an insurance carrier authorized by the State of Florida as a licensed provider of professional malpractice insurance must be in writing to the Board of Trustees.

3.2.12. ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person.

3.2.13. CRIMINAL ACTIVITIES

No individual shall be eligible for or continue to hold medical staff membership or clinical privileges when the individual has an indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence against another, or (v) related to the practice of a health care profession and/or the safety of patients and staff, even if not yet excluded, debarred, or otherwise declared “Ineligible”.

3.3. HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the staff or shall be granted clinical privileges if the hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Board may decline to accept, or have the staff review requests for staff membership and/or particular clinical privileges in connection with appointment, reappointment, the initial granting of clinical privileges, requests for revision of clinical privileges, the renewal of clinical privileges or otherwise on the basis of the following:

3.3.1. AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.  

3.3.2. EXCLUSIVE CONTRACTS

The Board may determine, in the interests of quality of patient care and as a matter of policy, that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified practitioners.

3.3.3. MEDICAL STAFF DEVELOPMENT PLAN

The Board may decline to accept applications based on the requirements or limitations in the hospital’s Medical Staff Development Plan which shall be based on identification by the hospital of the patient care needs within the population served.

3.3.4. EFFECTS OF DECLINATION

Refusal to accept or review requests for staff membership or clinical privileges based upon hospital need and ability to accommodate, as described in this section, shall not constitute a denial of staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application

60 MS.06.01.01
61 MS.06.01.03, MS.06.01.07, MS.08.01.03
which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accordance with these bylaws.

3.4. EFFECTS OF OTHER AFFILIATIONS

No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a Member of any professional organization, is certified by any board, or has/had staff membership or clinical privileges in another hospital or health care organization.62

3.5. NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of race, creed, color, religion, gender, sexual orientation, gender identity/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national or ethnic origin.63

3.6. BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

3.6.1. Appear for any requested interviews by phone or in person regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant’s performance;

3.6.2. Be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. (“Appropriate coverage” means coverage by another member of the Medical Staff with specialty-specific privileges equivalent to the Practitioner for whom he or she is providing coverage.)64 Compliance with this eligibility requirement means that the Practitioner must document that he or she is willing and able to:

3.6.2.1. Appear in person to attend a patient within 30 minutes, when requested to do so by the practitioner caring for the patient at the Hospital, if the practitioner believes it is a threat of loss of life or limb or permanent disability;65

3.6.2.2. Seek consultation whenever required or necessary;

3.6.2.3. Demonstrate recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care;

3.6.2.4. Complete the Hospital’s new physician/practitioner orientation within a timeframe defined by the hospital;

3.6.2.5. Comply with the Medical Staff policy for practitioner health & wellness by immediately submitting to an evaluation as required when there are identified, credible concerns with the individual’s ability to safely and competently care for patients;

62 42 C.F.R. §482.12(a)(7)
63 LD.04.01.01
64 EMTALA
65 EMTALA
3.6.2.6. Within the scope of clinical privileges granted, to provide on-call coverage for emergency care services within his/her clinical specialty, as required by the Hospital or the Medical Staff;

3.6.2.7. Comply with clinical practice protocols and evidence-based medicine guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance; and

3.6.2.8. Agree that, if there is any misstatement in, or omission from the Request for Consideration, Recredentialing Request for Consideration or application, the Hospital may stop processing (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual’s response and provide a recommendation to the Medical Executive Committee. The Medical Executive committee will recommend to the Board of Trustees whether the application should be processed further. In either situation, there shall be no entitlement to a hearing or appeal.

3.6.2.9. Abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital;

3.6.2.10. Abide by all local, State and Federal laws and regulations, The Joint Commission standards, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;

3.6.2.11. Regularly attend meetings of the Medical Staff unless excused;

3.6.2.12. Discharge such Medical Staff, Department, Division, committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff;

3.6.2.13. Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital;

3.6.2.14. Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;

3.6.2.15. Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;

3.6.2.16. Participate in continuing education to maintain clinical skills and current competence;66

3.6.2.17. Notify and update the Medical Staff and Hospital immediately [“immediately” defined as within one business day of being notified of a change] upon a change in any qualifications for membership or clinical privileges, as listed in Article

66 MS.12.01.01
Three of these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person);

3.6.2.18. Agree that the Hospital may obtain an evaluation of the applicant’s performance by a consultant selected by the Hospital if the Hospital considers it appropriate; and,

3.6.2.19. Perform such other responsibilities as the Hospital or the Medical Staff may require.

3.7. TERMS OF APPOINTMENT

Initial appointments and initial granting of clinical privileges shall be for a period of one year (12 months), and subject to extension for a total period not to exceed two years (24 months). 67 Reappointments shall be for a period not to exceed two years (24 months). 68 In the event that reappointment has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual will be considered to have been voluntarily surrendered. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to submit a new application if continued membership or clinical privileges are desired. Voluntary surrender of membership and/or clinical privileges shall not entitle the individual to a fair hearing and appeal.

3.8. CREDENTIALS VERIFICATION AND APPLICATION PROCESSING PROCEDURES

3.8.1. INITIATING A REQUEST FOR CONSIDERATION

Upon receipt of an initial request to apply for Staff membership or clinical privileges, the Medical Staff Office shall ask the person requesting Staff membership or clinical privileges to supply the following information to determine eligibility:

3.8.1.1. Name, degree, address, National Provider Identification (NPI), date of birth and social security number

3.8.1.2. Office information:

3.8.1.2.1. Group practice name, if applicable;

3.8.1.2.2. Address information;

3.8.1.3. Specialty (primary and secondary);

3.8.1.4. Primary contact information: name and phone/email; and,

3.8.1.5. Specialty board certification status.

3.8.1.6. The information listed above shall be used to verify that:

3.8.1.6.1. The service to be provided by the individual requesting an application is available at the Hospital;

3.8.1.6.2. The specialty of the individual requesting an application is open at the Hospital;

3.8.1.6.3. The specialty is not covered by exclusive contract at the Hospital;

67 MS.06.01.07
68 MS.06.01.07
3.8.1.6.4. The individual is located or is arranging to be located within the geographic parameters required to be eligible for membership, or to ensure adequate response time for the clinical privileges requested;

3.8.1.6.5. The individual is specialty board certified.

3.8.1.7. Based on the evaluation described above, if the individual is initially determined to be eligible, the forms necessary to begin a more thorough evaluation process shall be provided to the individual. The CPC will send a Request for Consideration (RFC).

3.8.2. APPLICATION

A separate credentials file shall be maintained for each applicant for Staff membership or clinical privileges. Each application for Staff appointment, reappointment, and/or clinical privileges shall be in the format prescribed by the Hospital, and signed by the applicant. When an individual is applying for initial appointment or is initially requesting clinical privileges, he/she shall be provided an application form when he/she is deemed eligible to apply, and shall also be given a copy of these Bylaws, the Medical Staff Rules and Regulations and applicable departmental Rules and Regulations, and applicable Hospital policies. Prior to expiration of the current term of membership or clinical privileges for an individual who is a Member of the Medical Staff or who currently holds clinical privileges, the individual should be sent a notice of the impending expiration and Recredentialing Request for Consideration (R-RFC) for reappointment and/or renewal of privileges.

3.8.3. BURDEN ON APPLICANT

Individuals seeking appointment, reappointment and/or clinical privileges have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual’s qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges or scope of practice, including, but not limited to, information from other hospitals, information from the individual’s office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

3.8.3.1. Individuals seeking appointment, reappointment and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the RFC or RRFC are accurate and complete.

3.8.3.2. The individual seeking appointment, reappointment, or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

3.8.3.3. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant shall provide accurate, up-to-date information on the Request for Consideration form, and shall be

---

69 42 C.F.R. §482.22(a)(2), Guidance to Surveyors  
70 LD.03.04.01
responsible for ensuring that all supporting information and verifications are provided, as requested. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities is submitted directly to the Credentials Processing Center by such sources. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the Request for Consideration the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the Request for Consideration may be stayed and the Request for Consideration may not be considered complete until such additional information or verification is received, or the interview is conducted. Any Medical Staff committee or the Board may request that the applicant appear for an interview with regard to the Request for Consideration. The Credentials Processing Center shall notify the applicant by special notice of the specific information being requested, the time frame within which a response is required, and the effect on the Request for Consideration if the information is not received timely.

3.8.3.4. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete thirty (30) days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

3.8.3.5. Medical Staff Services shall oversee the process of analyzing the information gathered by the CPC, and confirming that all references and other information or materials deemed pertinent have been received.

3.8.3.6. Failure to provide a complete Request for Consideration, as defined in these Bylaws, within six months after being provided with a Request for Consideration form for appointment, reappointment or clinical privileges, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the Request for Consideration process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Credentials Processing Center shall provide special notice to an individual regarding his/her withdrawal from the Request for Consideration process due to lack of requested information or failure to appear for an interview.

3.9 REQUEST FOR CONSIDERATION (RFC) / RECREREDENTIALING REQUEST FOR CONSIDERATION (RRFC)

An RFC or RRFC shall contain a request for specific clinical privileges if privileges are being sought, and shall require detailed information concerning the individual’s professional qualifications.

3.9.1. RFCs may be provided to residents, fellows, or advanced practice professionals who are in the final six months of their training. Such RFCs may be processed, but final action shall not be taken until all applicable Threshold Eligibility Criteria are satisfied.
3.9.2. In addition to other information, the RFC/RRFC shall seek the following:

3.9.2.1. Identifying information, including copy of current government-issue photo ID (driver's license/passport), full name as reflected on professional license, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background. Verification of identity may be performed by a current/licensed notary public and documented with a notarized statement, or verification may be performed by the staff of Medical Staff Services provided that the applicant physically presents himself/herself for the verification process before the application may be considered complete.

3.9.2.2. For new applicants, evidence of citizenship in the United States of America (e.g., birth certificate showing place of birth in this country, naturalization papers, or USA passport), or evidence that the applicant is in the USA legally and has the required permission(s) to work in this country. For applicants who are not USA citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required.

3.9.2.3. For a new applicant, written permission for a background check, and submission of any fees associated with processing a background check.

3.9.2.4. Evidence of current, unlimited, unrestricted licensure in the State of Florida and information from the individual regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;^71

3.9.2.5. For individuals requesting medication prescribing privileges, evidence of a current, unlimited, unrestricted Federal DEA listing a Florida in-state address, and evidence of a current, unlimited, unrestricted state controlled substance registration, if applicable;

3.9.2.6. For a new applicant, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate;^72

3.9.2.7. For applicants for appointment who are not newly graduated from residency or fellowship program within the last year, and for applicants for reappointments or renewal of clinical privileges, the applicant’s participation in continuing education, specifically as related to the clinical privileges requested;^73

3.9.2.8. The names of at least two peers practicing in the same or like professional discipline as the individual who will provide a written evaluation of the applicant’s medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the...

^71 MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(2), Guidance to Surveyors, HCA Requirement

^72 MS.06.01.03, MS.06.01.07, MS.08.01.03, Intent, 42 C.F.R. §482.22(a)(2)

^73 MS.12.01.01
clinical privileges requested. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal;\textsuperscript{74}

3.9.2.9. Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of all qualifying and certifying examinations taken, the results of each qualifying and/or certifying examination, and dates of board certification;

3.9.2.10. Have successfully completed an accredited ACGME/AOA/CPME, ADA residency training program (as defined by these organizations) in the specialty in which the applicant seeks clinical privileges or in the specific case of Emergency Medicine, meet the above Condition or be Board certified by the ABEM. Fast Track physicians may be Board Certified in Internal Medicine or Family Medicine;

3.9.2.11. Information regarding all current and all past healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;\textsuperscript{75}

3.9.2.12. Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;

3.9.2.13. Medicare Provider National Provider Identification (NPI);

3.9.2.14. Information as to any current, possible, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;\textsuperscript{76}

3.9.2.15. Accurate and complete disclosure with regard to the following queries:

3.9.2.15.1. Whether the applicant’s professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;\textsuperscript{77}

3.9.2.15.2. Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital;\textsuperscript{78}

\textsuperscript{74} MS.06.01.03, MS.06.01.07, MS.08.01.03, MS.07.01.03, 42 C.F.R. §482.22(a)(2)

\textsuperscript{75} MS.06.01.03

\textsuperscript{76} HCA, Ethics & Compliance Policy QM.002

\textsuperscript{77} MS.06.01.07

\textsuperscript{78} MS.06.01.07
3.9.2.15.3. Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and. 79

3.9.2.15.4. Whether the applicant has ever been subject to a criminal activity as defined in these Bylaws, or whether any such action is pending.

3.9.2.16. A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.2.9. 80

3.9.2.17. Evidence that the applicant has complied with health screening and immunization requirements;

3.9.2.18. A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly adopted; 81

3.9.2.19. A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;

3.9.2.20. A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant’s health status as required by Section 3.2.9, and for a new applicant a permission to conduct a background check, and a statement providing absolute immunity and release from civil liability for all individuals requesting or providing information relative to the applicant’s professional qualifications or background, or evaluating and making judgments regarding such qualifications or background;

3.9.2.21. A statement from the applicant consenting to the release of information and providing absolute immunity and release from civil liability to all individuals providing information relative to the applicant’s professional qualifications or background in association with future requests received by the Hospital from other healthcare organizations authorized to request such information;

3.9.2.22. A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings;

3.9.2.23. All physicians and other practitioners shall submit a signed Medicare Physician Acknowledgement Statement. The physician or other practitioner must complete the acknowledgment at the time he or she is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by physicians already on staff remain in effect as long as the

79 MS.06.01.07
80 MS.06.01.03, 42 C.F.R. §482.22(c)(4)
81 LD.03.04.01
physician has admitting privileges at the hospital. Physicians, other Practitioners, and Advanced Practice Professionals will sign an Information Security Agreement at the time of application for initial appointment, and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy policies of the Hospital. Completed Agreements will be maintained in the individual’s credentials file;  

3.9.2.24. Unless the applicant is applying for medical staff membership only, all applications must include a specific written request for clinical privileges using prescribed forms. Requests for clinical privileges shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested; and

3.9.2.25. As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to immediately provide (within one business day of being officially notified of a change in status) to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual’s professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a QIO citation, any change in legal status to reside and/or work in the USA, any investigation by an ABMS or AOA specialty board, any payer contract termination, any change in health status, any change in location of office or residence, any criminal investigation, and/or a quality denial letter concerning alleged quality problems in patient care.

3.10. VERIFICATION PROCESS

Upon the receipt of a completed Request for Consideration or Re-Request for Consideration form, the Credentials Processing Center shall arrange to verify the qualifications and obtain supporting information relative to the application. The Credentials Processing Center shall consult primary sources of information about the applicant’s credentials, where feasible. Completion of a background check, verifications of licensure, controlled substance registration, specialty board certification, and professional liability claims history, a query of the NPDB, and queries of the OIG Sanction Report and GSA List, shall be done within 150 days prior to the Board receiving the application; if there are delays in completing the application, any of these verifications or queries that were done more than 150 days before the Board is scheduled to receive the application shall be repeated. Verifications may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Credentials Processing Center and the verification is documented. If the primary source has designated another

82 42 C.F.R. §412.46(c)
83 HCA Ethics & Compliance Policy IS.SEC.005
84 42 C.F.R. §482.22(a)(2)
85 MS.06.01.03
organization as its officially-designated agent in providing information to verify credentials, the Credentials Processing Center may use this other organization as the designated equivalent source.86 The Credentials Processing Center shall promptly notify the applicant of any problems in obtaining required information. Any action on a Request for Consideration shall be withheld until the Request for Consideration is completed; meaning that all information has been provided and verified, as defined in these Bylaws.87 The following information shall be verified for all applicants for appointment, reappointment, or clinical privileges, except as specified:

3.10.1. Current licensure shall be verified in the State of Florida through the applicable state licensure board for all applicants.88 Additionally, information about previous, current and future disciplinary actions by any State licensure board shall be obtained through ongoing monitoring of a disciplinary action alert register.

3.10.2. For individuals requesting prescribing privileges, federal DEA registration shall be verified through the US Department of Commerce, National Technical Information Service’s electronic verification mechanism.

3.10.3. For new applicants, completion of medical school or other postgraduate programs appropriate to the applicant’s healthcare profession shall be verified through the school’s registrar’s office, or the National Student Clearinghouse if designated by the school to provide degree verification, and/or through the ECFMG in the case of a foreign medical school graduate.89 The American Medical Association (AMA) profile, the American Osteopathic Association (AOA) profile and/or the Federation Credentials Verification Service (FCVS) profile may be used as a secondary source of information only. For applicants for reappointment or renewal of privileges, information about the topics and content of the applicant’s continuing education shall be documented and considered as related to the privileges requested.90

3.10.4. For new applicants, their internship, residency, or other applicable postgraduate training shall be verified through the program’s registrar’s office or program director’s office.91

3.10.5. For new applicants, a background check, as defined by Hospital policy, shall be obtained. The background check shall be used in part to verify that the individual requesting approval is the same individual identified in the credentialing documents.92

3.10.6. Information reported pursuant to the HCQIA shall be obtained from the National Practitioner Data Bank.93

3.10.7. The OIG Sanction Report, and the GSA List shall be checked to ensure that the applicant is not listed.94

86 MS.06.01.03
87 MS.06.01.03, MS.06.01.07, MS.08.01.03
88 MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(2)
89 MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(2)
90 MS.12.01.01
91 MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(2)
92 MS.06.01.03 (3)
93 42 U.S.C §11135, 45 C.F.R §60.10
94 HCA, Ethics & Compliance Policy QM.002
3.10.8. Professional liability insurance and claims history shall be verified through the insurance carrier(s).

3.10.9. For new applicants, information about the applicant’s membership status and/or work history shall be obtained from all organizations where the applicant currently has membership or privileges and/or is employed, and where the applicant has held membership or has been granted clinical privileges and/or has been employed during the previous five years. For applicants seeking reappointment or renewal or increase in clinical privileges, information about the applicant’s membership status shall be obtained from all organizations where the applicant currently holds membership or has current clinical privileges.

3.10.10. Data and information regarding professional performance shall be requested from available sources:

   3.10.10.1. Relevant applicant-specific data as compared to aggregate data;
   3.10.10.2. Morbidity and mortality data.  

3.10.11. The applicant’s health status as applicable to their ability to perform the clinical privileges requested shall be verified in accordance with Article Three, Section 3.1.9, and as part of information requested from the applicant’s peers, or in the case of an applicant for reappointment, from the applicant’s Department Chairperson.

3.10.12. Evaluations from the applicant’s peers shall be obtained. Two peer references shall be required. Peer evaluations shall include written information regarding the applicant’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

3.10.13. Before recommending privileges, the Medical Staff shall use a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privileges. For a new applicant or an applicant for renewal or increase in clinical privileges information regarding the applicant’s number of cases, treatment results and conclusions drawn from quality assessment, performance improvement activities, and other information regarding the applicant’s history of meeting the criteria for membership or clinical privileges including information about ability to adhere to Hospital policies regarding personal and professional conduct, as defined in these Bylaws, shall be assembled for review. Relevant applicant-specific information from organization performance activities shall be considered and compared to aggregate information when evaluating professional performance, judgment, and clinical or technical skills at the time of reappointment, or renewal or revision of clinical privileges.

95 MS.06.01.07; MS.08.01.03
96 MS.06.01.03, MS.06.01.07, MS.08.01.03
97 MS.06.01.03, MS.06.01.07, MS.08.01.03, MS.07.01.03, 42 C.F.R. §482.22(a)(2)
98 MS.06.01.05
99 MS.06.01.05
100 MS.06.01.07, 42 C.F.R. §482.22(a)(2)
3.10.14. Specialty board certification shall be verified through the American Board Medical Specialties (ABMS), the Bureau of Osteopathic Specialists, the American Board of Podiatric Surgery (ABPS) and the American Board of Oral/Maxillofacial Surgeons (ABOMS), as applicable.

3.10.15. In regard to new applicants for Staff membership or clinical privileges, or applicants for reappointment who are not active at the Hospital, evidence of qualifications and competence shall be verified through correspondence with the Medical Staff offices of other facilities where the applicant is affiliated and actively practicing.101

3.11. APPLICATION PROCESSING

3.11.1. Once completed and all information is verified by the CPC, the RFC/RRFC shall be turned over to the Hospital for processing as an application.

3.11.2. By requesting an RFC, RRFC, application, and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section.

3.11.3. By applying for and/or accepting appointment to the Medical Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant, Medical Staff appointee, and individual who is granted clinical privileges extends absolute immunity to, and releases from all claims, damages and liability whatsoever.

3.11.4. The Hospital and the Board of Trustees, any member of the Medical Staff and the Board of Trustees, their authorized representatives, and third parties who provide information for any matter relating to Requests for Consideration, Recredentialing Requests for Consideration, appointment, reappointment, clinical privileges, or the individual’s qualifications for the same.

3.11.5. Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning the individual whether the individual is a former or current applicant or Medical Staff appointee unless such information is false and the third party providing it knew it was false.

3.11.6. The immunity provided by the Medical Staff Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital’s activities, including, but not limited to:

3.11.6.1. Applications for appointment and/or clinical privileges;

3.11.6.2. Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;

3.11.6.3. Corrective action;

3.11.6.4. Hearings and appellate reviews;

3.11.6.5. Patient care audits;

3.11.6.6. Medical care evaluations;

3.11.6.7. Utilization reviews;

101 MS.06.01.03, MS.06.01.07, MS.08.01.03, MS.07.01.03, 42 C.F.R. §482.22(a)(2)
3.11.6.8. Other Hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

3.11.6.9. Matters or inquiries concerning the credentials of any applicant, Medical Staff appointee, or Practitioner with clinical privileges;

3.11.6.10. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and

3.11.6.11. Reports to the National Practitioners Data Bank established pursuant to the Health Care Quality Improvement Act of 1986.

3.12. AUTHORIZATION TO OBTAIN INFORMATION FROM THIRD PARTIES

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives:

3.12.1. to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential;

3.12.2. to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff; and

3.12.3. to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions.

3.12.4. The individual also specifically authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any Hospital Representative, and consents to the inspection and procurement by any Hospital Representative of such information, records and other documents. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct criminal background check on the individual and report the results to the Hospital.

3.13. BACKGROUND INVESTIGATION

The individual requesting initial appointment or initial clinical privileges shall provide written permission to conduct a background investigation as part of the initial credentials verification process and on an ad hoc basis upon request by the Chief Executive Officer.

3.13.1. Circumstances that may trigger a request for an ad hoc background investigation include, but are not limited to:

3.13.1.1. Disciplinary action against the individual’s license;

3.13.1.2. Sanctions or revocation of the individual’s Federal DEA or State narcotic registration;

3.13.1.3. Identification of felony or misdemeanor arrests or convictions; or
3.13.1.4. Reports of disruptive behavior, harassment, professional misconduct, or substance abuse.

3.14. AUTHORIZATION TO MAINTAIN INFORMATION
The individual authorizes the Hospital to maintain information concerning the individual’s specialty, demographic information, training, board certification, licensure and other confidential information in a centralized Practitioner data base for the purpose of making aggregate Practitioner information available for use by the Hospital and its affiliates.

3.15. AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTIES
The individual authorizes Hospital representatives to release information to the Hospital’s affiliated management entities (e.g., Division office), other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The individual also authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the Practitioner to peer review committees of the Hospital and affiliates of the Hospital for purposes of reducing morbidity and mortality and for the improvement of patient care.

3.16. HEARING AND APPEAL PROCEDURE
The individual agrees that the hearing and appeal procedures set forth in these Bylaws are the sole and exclusive remedy with respect to any professional review action taken by the Hospital and agrees that, if any adverse action is made with respect to him or her, (1) he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the Hearing Procedure as a prerequisite to any other action, and (2) he or she will have the burden of demonstrating that he or she meets the standards for appointment or continued appointment to the Medical Staff or for the clinical privileges requested.

3.17. REPORTING
The individual consents to the reporting by any Hospital Representative of information to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, and to other Federal agencies or to State agencies as required by laws, statutes or regulation, which such Hospital Representative believes in good faith is required by law to be reported.

3.18. AGREEMENT TO IMMEDIATELY NOTIFY HOSPITAL OF CHANGES IN INFORMATION
The individual shall specifically agree to immediately provide in writing within one business day of being officially notified of a change in status, a notice to the Medical Staff and the Hospital, with or without request, of any new or updated information that is pertinent to the individual’s professional qualifications or any question on the RFC/RRFC form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the U.S. Department of Health and Human Services or any state, the receipt of a Quality Improvement Organization (QIO) citation, any change in legal status to reside and/or work in the USA, any investigation by a specialty certification board, any payer contract termination, any change in health status, any change in location of office or residence, loss of on-call coverage, any criminal investigation, termination of or notice of non-renewal of professional liability insurance coverage, initiation of any
corrective action by any health care facility or professional organization, and/or a quality
denial letter concerning alleged quality problems in patient care.

3.19. **FINALIZATION OF APPLICATION PROCESSING**

After verification is accomplished and the RFC or RRFC is deemed fully complete and it
has been verified that all Threshold Eligibility Criteria have been met, the information
shall be submitted as an application and it shall be reviewed and processed as follows.\(^{102}\)

3.19.1. The names of applicants shall be posted so that members of the Medical Staff
may submit, in writing, information bearing on the applicant’s qualifications for
appointment or clinical privileges.

3.19.2. **Time Period for Processing:** Once an application is deemed complete, it is
expected to be processed within 150 days, unless it becomes incomplete. This
time period is intended to be a guideline only and shall not create any right for
the applicant to have the application processed within this precise time period. If
the action of the Board of Trustees has not been taken within 150 days after an
application is turned over by the CPC for MSO File Review, the verifications
must first be repeated to assure that the information is current before the Board
of Trustees takes action.

3.19.3. **Determination of Clinical Privileges:** Determination of initial clinical privileges
shall be based upon the professional criteria used in evaluating applicant’s
credentials for Medical Staff appointment, and the professional criteria
established by the Hospital for specific clinical privileges. In the course of
development of its recommendation concerning an applicant’s request for
clinical privileges, the Credentials Committee shall forward to the Chairperson
of the applicable Department the applicant’s qualifications and request for
clinical privileges. This request shall be communicated through a summary of
the pertinent information, such as the electronic Cactus profile and supporting
documents. Following receipt of the Department Chairperson’s recommendation
regarding the applicant’s clinical privileges, the Credentials Committee shall
consider such recommendation and, if the committee concurs, report to the
Medical Executive Committee its recommendations for privileges to be granted
applicant. The written comments of the Medical Executive Committee, if any,
will be forwarded to the Board of Trustees simultaneously with the
recommendation of the Credentials Committee. Should the Credentials
Committee not concur with the Department Chairperson’s recommendation for
clinical privileges, the request may be returned to the Department Chairperson
for further consideration. The time frame for completion of the Department
report(s) shall be within 30 days of receipt of a complete application.\(^{103}\) For
Advanced Practice Registered Nurses (ARNPs), since they provide nursing care,
treatment and services, their practice shall be under the supervision and direction
of the Chief Nursing Officer (CNO)\(^ {104}\) in addition to Medical Staff oversight.
Therefore, the CNO shall make an evaluation and provide recommendations
regarding the clinical privileges to be granted to an ARNP, and any concerns
regarding the clinical privileges requested or level of supervision needed.

---

\(^{102}\) MS.01.01.01, MS.06.01.07, MS.08.01.03

\(^{103}\) MS.01.01.01, MS.06.01.07, MS.08.01.03, LD.04.01.05

\(^{104}\) NR.01.01.01, 42 C.F.R. §482.23
3.19.4. **Department Report:** The Medical Staff Services shall make available the application and all supporting materials to the Chairperson of each Department in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department to be assigned, the Division to be assigned if appropriate to the applicant’s practice, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested. In the event that the applicant is the Department Chairperson, the President of the Medical Staff or the Department Vice-Chairperson shall make the evaluation and recommendations. Following the Department Chairperson(s)’ evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application.

3.19.5. **Credentials Committee Report:** The Credentials Committee shall receive from the Department Chairperson and review the application, supporting materials, the report of the Department Chairperson and any such other available information as may be relevant to the applicant’s qualifications. The Credentials Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Division to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Department report, to be within 30 days.

3.19.6. **Criteria for Additional Inquiry:** Additional inquiry shall be conducted by the Department Chairman, Credentials Committee, or Medical Executive Committee for any of the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the Request for Consideration. The Request for Consideration shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Department Chairman, Credentials Committee, Medical Executive Committee or Board of Trustees:

- **3.19.6.1.** Inability to verify any of the information or credentials represented in the Request for Consideration;
- **3.19.6.2.** Any unexplained gaps in medical staff membership, clinical privileges and/or work history;
- **3.19.6.3.** Any other inconsistent or less than favorable information about the applicant’s professional qualifications, competence or character, as judged by the Department Chairman Credentials Committee, Medical Executive Committee or Board of Trustees.

3.19.7. **Medical Executive Committee Recommendation:** The Medical Executive Committee shall receive from the Credentials Committee and review the Request for Consideration, supporting materials, the reports of the Department Chairperson and the Credentials Committee, and any such other available

---

105 MS.01.01.01, MS.06.01.07, MS.08.01.03, LD.04.01.05
106 MS.01.01.01, MS.06.01.07, MS.08.01.03, LD.04.01.05
information as may be relevant to the applicant’s qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff appointment and staff category in the case of applicants for Staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee report, to be within 30 days.

3.19.8. 

Effect of Medical Executive Committee Recommendation


Deferral: The Medical Executive Committee may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the Medical Executive Committee to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The Medical Executive Committee may delegate the responsibility for further consideration to the Credentials Committee or Department Chairperson as deemed appropriate.

3.19.8.2. 

Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the Board for action at the Board’s next regular meeting.

3.19.8.3. 

Adverse Recommendation: If the recommendation of the Medical Executive Committee is adverse under Article Seven of these Bylaws, the President of the Medical Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Seven of these Bylaws, and the recommendation need not be transmitted to the Board until after the applicant has exercised or waived such rights.

3.19.9. 

Board Action: Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board shall act on the application at its next regular meeting following receipt of the recommendation from the Medical Executive Committee. The action of the Board shall be taken within 30 days after receiving a recommendation from the Medical Executive Committee.

3.19.9.1. 

If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.

107 42 C.F.R. §482.22(a)(2), MS.02.01.01
108 42 C.F.R. §482.12(a)(2), 42 C.F.R. §482.22(a)(2), MS.01.01.01, MS.06.01.03, MS.06.01.07
3.19.9.2. If the Board does not adopt the recommendation of the Medical Executive Committee, the Board may either refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may take unilateral action. If the matter is referred back to the Medical Executive Committee, the Medical Executive Committee shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.

3.19.9.3. If the action of the Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Seven of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant’s hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action.

3.19.9.4. All decisions to appoint shall include a delineation of clinical privileges, the assignment of a staff category and Department affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.

3.19.9.5. Subject to any applicable provisions of Article Seven, notice of the Board’s final decision shall be given in writing through the Secretary of the Board to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal was held, Article Seven shall govern notice of the Board’s final decision.

3.20. CREDENTIALS SUBJECT TO ONGOING VERIFICATION

3.20.1. In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, as described in Section 3.8 of this Article, at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall result in automatic suspension actions as provided in these Bylaws and shall be reported to the Credentials Committee:

3.20.1.1. Current licensure;

3.20.1.2. Drug Enforcement Administration registration, as applicable to specialty;

3.20.1.3. Professional liability insurance or self insurance;

3.20.1.4. Specialty board certification, if required for membership or any of the clinical privileges granted;

3.20.1.5. Privilege-specific requirements for current certifications as applicable to the clinical privileges granted; and,
3.20.1.6. Eligible to participate in the Federal Health Care Program. (The OIG Sanction Report and the GSA List shall be checked according to the frequencies defined by hospital policy.)

3.20.2. To be eligible to complete a Recredentialing Request for Consideration (RRFC) or apply for reappointment and renewal of clinical privileges, an individual must satisfy the criteria defined in these Bylaws, and during the previous appointment term shall have:

3.20.2.1. Completed all medical records;
3.20.2.2. Completed all continuing medical education requirements;
3.20.2.3. Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested;
3.20.2.4. For individuals requesting clinical privileges, the individual had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital, defined as less than eleven patient encounters, must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual’s private office practice, and/or a quality profile from a managed care organization) before the RRFC shall be considered complete and processed further, or the applicant may consider changing his/her Medical Staff category to Affiliate or Community, whichever best suits the provider's clinical activity during the current reappointment cycle; and,
3.20.2.5. Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested.

3.21. EXPIRATION OF CURRENT APPOINTMENT

3.21.1. If a complete RRFC is not submitted timely, the individual’s appointment and clinical privileges shall expire at the end of the then current term of appointment. Only after a complete application is received by the Hospital from the CPC shall an individual be considered for reappointment or renewal of clinical privileges.

3.21.2. If a complete application for reappointment is submitted timely, but the Board of Trustees has not acted on it prior to the end of the current term, the individual’s appointment and clinical privileges shall expire at the end of the current term of appointment while the application for reappointment and/or renewal of clinical privileges continues to be processed and reviewed. The Board of Trustees may subsequently grant reappointment and renewal of clinical privileges on a go forward basis.

---

109 HCA Ethics & Compliance Policy QM.002
110 MS.06.01.09, EP 9; §482.22(a)(1)
3.22. ASSISTANCE WITH EVALUATION

The Board, the Medical Executive Committee, the Chief Executive Officer, or any committee authorized to review or evaluate applications for Staff membership or clinical privileges, or conduct ongoing review or evaluation of performance of those who currently hold Staff membership or clinical privileges, may as part of these duties:

3.22.1. Obtain the assistance of an independent consultant or others to evaluate the healthcare professional being subject to review;

3.22.2. Consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the healthcare professional under evaluation;

3.22.3. Request or require the healthcare professional under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;

3.22.4. Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the healthcare professional under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,

3.22.5. Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the healthcare professional under evaluation, including information concerning threatened or pending legal or administrative proceedings.

3.23. PROVISIONAL STATUS AND PROCTORING

The Medical Staff shall have a process to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of performing the requested privilege at the Hospital. This process may also be used when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care. Therefore, when an initial applicant seeks clinical privileges, or an individual with existing clinical privileges seeks new privileges, or when the Medical Staff requires the individual’s actual clinical competence be evaluated for any other reason, the individual shall undergo a Focused Professional Practice Evaluation. This process of focused professional practice evaluation shall be a time-limited period during which the Medical Staff evaluates and determines the practitioner’s professional performance. Focused professional practice evaluation may entail the use of one or more types of evaluation, including but not limited to chart review, monitoring of clinical practice patterns, simulation, clinical proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).\(^{111}\) Clinical proctoring is an objective evaluation of an individual’s actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff. In most instances, proctors act as monitors to evaluate the technical and cognitive skills of another Practitioner and do not directly participate in patient care, have no physician/patient relationship with the patient being treated, do not receive a fee from the patient, represent the Medical Staff, and are responsible to the Medical Staff.\(^ {112} \)

3.23.1. For initial appointment/initial clinical privileges: At the time of initial appointments and initial granting of clinical privileges, the department chairperson shall determine a plan for conducting focused professional practice

\(^{111}\) MS.08.01.01

\(^{112}\) AMA Board of Trustees Report 30-A-94
evaluation, during which the practitioner shall be on provisional status. The evaluation plan shall include method(s) and the time period of evaluation and may be subject to an extension of time for a total period not to exceed two years (24 months). A period of focused professional practice evaluation shall be implemented for all initially requested privileges. The provisional status individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the patient care and services provided by Department members. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual’s eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual’s performance. Proctoring report(s) will be evaluated by the Department Chairperson continuously in order to be aware of any undesirable trend or pattern that may be developing. At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status, or be extended on provisional status for an additional period not to exceed a total of twenty-four (24) months. Advancement shall be based upon a favorable recommendation of the individual’s Department Chairperson based on the Chairperson’s review of the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and a favorable recommendation of the Credentials Committee and Medical Executive Committee, and approved by the Board. No one may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the Medical Executive Committee and the Board, an individual’s failure to complete the required number of cases needed to complete focused professional practice evaluation shall be deemed a voluntary relinquishment of membership and clinical privileges; such individual shall not be entitled to the hearing and appeal rights under these Bylaws. Failure to advance to a non-provisional status due to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws.

3.23.2. For individuals with existing privileges who are requesting new privileges: A period of focused professional practice evaluation shall be implemented for all initially requested privileges. Medical Staff members or other individuals with existing clinical privileges who are requesting new privileges shall be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by the Department Chairperson to which the individual is affiliated. In the event new privileges are requested for which there are no other Medical Staff members or other individuals with existing clinical privileges and competence to proctor and evaluate someone in the new area of practice, the Credentials Committee, the Medical Executive Committee, and the Board shall have the option of specifying requirements for other evidence of competence, including but not limited to reports of completion of an accredited training program, evaluations from competent instructors, external peer review, and/or evidence of proctoring at another hospital. The individual requesting new privileges shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department Chairperson as appropriate to the new clinical privileges being requested. The care under evaluation shall be relevant to the privileges granted.

---

113 MS.08.01.01
114 MS.08.01.01
The purpose of the observation is to determine the individual’s actual clinical competence for the new clinical privileges granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual’s performance. Proctoring report(s) will be evaluated by the Department Chairperson continuously in order to be aware of any undesirable trend or pattern that may be developing. The individual’s Department Chairperson shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Credentials Committee, the Medical Executive Committee, and the Board.

3.23.3. For evaluating of clinical competence for privileges previously granted: Medical Staff members or other individuals with existing clinical privileges who are identified for review of actual clinical competence may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by the Department Chairperson to which the individual is affiliated. Focused professional practice evaluation may be indicated as the result of QA/PI, peer review or patient safety information, or due to inactivity with clinical privileges granted, or due to return from a leave of absence. The individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department Chairperson as appropriate to the clinical privileges subject to review. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual’s actual clinical competence for the clinical privileges subject to review. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual’s performance. Proctoring report(s) will be evaluated by the Department Chairperson continuously in order to be aware of any undesirable trend or pattern that may be developing. The individual’s Department Chairperson shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Medical or Surgical Care Review Committee, the Medical Executive Committee, and the Board.

3.24. CONDITIONAL APPOINTMENT, REAPPOINTMENT OR PRIVILEGES

3.24.1. Recommendations for appointment, reappointment, initial granting of privileges and/or renewal of privileges may be contingent upon an individual’s compliance with certain specific conditions. These conditions may relate to behavior (e.g., demonstration of compliance to code of conduct) or to clinical issues (e.g., general consultation requirements, requirements for proctoring, completion of CME requirements). Unless the conditions being imposed constitute a disciplinary action or are reportable as defined by the Health Care Quality Improvement Act, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article Seven of these Bylaws.

3.24.2. If the individual successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.

3.24.3. If the individual does not adhere to the conditions or completes the requirements specified in the conditional appointment, reappointment, or privileges then corrective actions as set forth in Article Six of these Bylaws shall commence.

115 MS.08.01.01
3.24.4. If the individual refuses to accept conditional appointment, reappointment, or privileges or any of the conditions or requirements, then the procedures as set forth in Article Six of these Bylaws shall apply.

3.24.5. Conditional appointment, reappointments, or privileges may be recommended for periods of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions that may be imposed. A recommendation for appointment, reappointment, or privileges for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article Seven of these bylaws.

3.24.6. In the event an applicant for reappointment or renewal of privileges is the subject of an investigation or hearing at the time reappointment or renewal of privileges is being considered, a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the investigation or hearing.

3.24.7. To end a term of conditional appointment, reappointment, or privileges the individual shall be required to undergo all usual reappointment and privileging procedures.

3.25. PREVIOUSLY DENIED OR TERMINATED APPLICANTS

Notwithstanding any other provisions in these Bylaws, if a Request for Consideration is tendered by an individual who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the Request for Consideration is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the Request for Consideration shall be deemed insufficient by the Credentials Committee and returned to the individual as unacceptable for processing. If a Request for Consideration is tendered by an individual who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to circumstances that permanently disqualify the applicant for membership, as has been so designated by prior action of the Board of Trustees, then the Request for Consideration shall be returned to the individual as unacceptable for processing. No Request for Consideration shall be processed, and no right of hearing or appeal shall be available in connection with the return of such Request for Consideration.

3.26. MEDICO-ADMINISTRATIVE OFFICERS

3.26.1. DEFINED

A medico-administrative officer is a Practitioner who is employed by or contracts with the Hospital, or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities, and may also include clinical responsibilities.

3.26.2 STAFF APPOINTMENT, CLINICAL PRIVILEGES AND OBLIGATIONS

All individuals in administrative positions who desire Medical Staff membership or clinical privileges shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or a contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall delineate

116 MS.03.01.01, MS.03.01.03
the clinical privileges of Medico-Administrative officers who request to admit and/or treat patients.

3.26.3 EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES

In the event a Practitioner who is employed by or has contracted with the Hospital, or otherwise serves in a Medico-Administrative position pursuant to a contract, is subject to removal from office through the termination or expiration of employment or of the contract, full effect shall be given to any specific provisions in the contract regarding the consequence such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

An adverse action, as defined in these Bylaws, against a medico-administrative practitioner for clinical reasons or for violation of these Bylaws shall be subject to the hearing and appeal procedures in Article Seven of these Bylaws. Pursuant to any specific provisions of the contract, such adverse change in membership status or clinical privileges may result in termination of the contract. In the event there is a conflict between the terms of the contract and these Bylaws, the terms of the contract shall control.

3.27. INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.27.1 QUALIFICATIONS AND SELECTION

Practitioners providing clinical services pursuant to a contract, agreement or other arrangement or through Hospital employment shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or an agreement may be imposed. The Staff, as in the case of other Practitioners, shall recommend the clinical privileges to admit and/or treat patients for Practitioners who are Hospital employed, or providing services through a contract, agreement or other arrangement.

3.27.2 EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. Such contract may provide, for example, that the Staff membership and clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

117 MS.03.01.01, MS.03.01.03
3.28. LEAVE OF ABSENCE

A Medical Staff Member or Advanced Practice Professional (APP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Chief Executive Officer. Any absences/leaves from the Medical Staff for a period of more than thirty (30) days must be requested in writing. The request must state the beginning date and ending date for the period of leave desired, which may not exceed one year, and include the reasons for the request. The Medical Executive Committee shall review and recommend leave of absence requests to the Board of Trustees, but in extenuating circumstances such as military leave, the Chief Executive Officer and President of the Medical Staff shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Board of Trustees. During the period of leave, the Practitioner or APP shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the Medical Staff Member or APP requesting the leave. A leave of absence shall be granted for Medical Staff members or APPs in good standing, provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. Exceptions shall be allowed only in the event that a Medical Staff Member or APP has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

3.28.1. MEDICAL LEAVE OF ABSENCE

A Medical Staff Member or APP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or impairment. If an individual is unable to request a medical leave of absence because of a physical or psychological condition, the President of the Medical Staff or Chairperson of the individual’s Department may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of this action. Reinstatement of membership status and/or clinical privileges may be subject to production of evidence by the individual that he/she has the ability to perform the clinical privileges requested.

3.28.2. MILITARY LEAVE OF ABSENCE

A Medical Staff Member or APP may request and be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist shall submit a copy of deployment orders. Medical Staff members or APPs who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.28.3. EDUCATIONAL LEAVE OF ABSENCE

A Medical Staff Member or APP may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article Five of these Bylaws.
3.28.4. PERSONAL/FAMILY LEAVE OF ABSENCE

A Medical Staff Member or APP may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to “Doctors Without Borders/USA”) or family reasons (e.g., maternity leave). Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.28.5 TERMINATION OF LEAVE

The Medical Staff Member or APP on leave of absence may request reinstatement of Medical Staff membership and/or clinical privileges by submitting a written notice to the President of the Medical Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Three, Sections 3.9.2.1. - 3.9.2.22., or if changes have occurred, a detailed description of the nature of the changes. The Staff Member or APP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence has extended past the Practitioner’s or APP’s reappointment time, he/she will be required to submit an application for reappointment in accordance with Article Three of these Bylaws and the reinstatement shall be processed as a reappointment. A Practitioner or APP applying for reinstatement may apply for temporary privileges while the request for reinstatement is being processed, in accordance with Article Five, Section 5.4. The President of the Medical Staff will forward the request for reinstatement to the individual’s Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Article Five, Section 5.3.3. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

3.28.6. FAILURE TO REQUEST REINSTatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and/or voluntary relinquishment of clinical privileges. A request for Medical Staff membership or clinical privileges subsequently received from a Medical Staff Member or APP deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

3.29. RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to the Medical Staff Services. Resignation of Medical Staff membership and/or clinical privileges may
be granted for a Practitioner or APP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner’s or APP’s Department Chairperson, the Medical Executive Committee, and the Board shall review letters of resignation. Once submitted, a resignation may not be withdrawn until it has been considered by the Board. If a Practitioner or APP requests to withdraw a resignation before the resignation is accepted by the Board, the request for withdrawal shall also be forwarded to the Board for consideration. The Board may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board, the Practitioner or APP will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding improper conduct or incompetence, a report shall be submitted to the state professional licensing board for reporting to the NPDB, as required by federal law.118

The Practitioner will continue to follow patients or make arrangements for a minimum of thirty (30) days after submission of his/her letter of resignation.

3.30. ACTIONS INVOLVING AN IMPAIRED PRACTITIONER OR OTHER IMPAIRED INDIVIDUAL WITH CLINICAL PRIVILEGES

The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges. The process addresses physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of individuals who suffer from a potentially impairing condition.119 It is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a Member of the Medical Staff or who has clinical privileges is suffering from impairment. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA). An “Impaired Individual” is one who is unable to perform the clinical privileges that have been granted with reasonable skill and safety to patients or perform other Medical Staff duties because of physical, mental, emotional or personality disorders, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.120

3.30.1. SELF-REPORTING

During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff Member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change.121

3.30.1.1. An oral or preferably, a written report shall be given to the Chief Executive Officer, the President of the Medical Staff, the Chairperson of the individual’s Medical Staff Department, and/or the Chairperson of the Credentials Committee. The recipient of the report shall submit it, along with a written request to investigate, to the Credentials Committee.

3.30.2. THIRD PARTY REPORTS

118 Health Care Quality Improvement Act, 42 U.S.C. §11135, 45 C.F.R. 60.9(a)(ii)(A)
119 MS.11.01.01
120 AMA Definition of Impairment
121 MS.11.01.01
If a Medical Staff Member, Advanced Practice Professional, or Hospital employee witnesses warning signs of impairment they should report the incident. Patients, family members, or others who witness warning signs of impairment shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting signs of impairment shall be kept strictly confidential. Medical Staff members and others, as appropriate, shall be educated about illness and impairment recognition issues specific to physicians and others with clinical privileges, including education about warning signs. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

3.30.2.1. An oral or, preferably, a written report shall be given to the Chief Executive Officer, the President of the Medical Staff, the Chairperson of the individual’s Medical Staff Department, and/or the Chairperson of the Credentials Committee. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may be impaired. The person making the report does not need to have proof of the impairment, but must state the facts leading to the concern.

3.30.2.2. If, after discussing the incident(s) with the person who filed the report, the recipient of the report believes there is sufficient information to warrant further inquiry, the recipient of the report may:

3.30.2.2.1. Meet personally with the individual under inquiry or designate another appropriate person to do so; and/or,

3.30.2.2.2. Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Peer Review Committee.

3.30.3. INVESTIGATION

Following a written request to investigate, the Peer Review Committee shall investigate the concerns raised and any and all incidents that led to the belief that the individual may be impaired. The Committee’s investigation may include, but is not limited to, any of the following:

3.30.3.1. A review of any and all documents or other materials relevant to the investigation;

3.30.3.2. Interviews with any and all persons involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the individual’s health status are related to the performance of the individual’s clinical privileges and Medical Staff duties and are consistent
with proper patient care or the operations of the Hospital;

3.30.3.3. A requirement that the individual under investigation undergo a complete medical and/or psychological examination as directed by the Committee, so long as the exam is related to the performance of the individual’s clinical privileges and Medical Staff duties and is consistent with proper patient care or the operations of the Hospital, with the results of the examination to be provided to the Committee;

3.30.3.4. A requirement that the individual under investigation undergo urine drug screening, serum alcohol/drug level testing or other appropriate testing, with the results of the screening and/or testing to be provided to the Committee;

3.30.3.5. The Committee may meet with the individual under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital’s Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual’s legal counsel. At this meeting, the Committee may ask the individual under investigation health-related questions so long as they are related to the concerns related to performance of the individual’s clinical privileges and Medical Staff duties, and are consistent with proper patient care and operations of the Hospital. In addition, if the Committee feels that the individual may have an impairment that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the individual under investigation whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

3.30.4. OUTCOME OF INVESTIGATION

Based on all of the information it reviews as part of its investigation, the Peer Review Committee shall determine:

3.30.4.1. Whether the individual is impaired, or what other problem, if any, is affecting the individual under investigation;

3.30.4.2. If the individual is impaired, the nature of the impairment and whether it is classified as a disability;

3.30.4.3. If the individual’s impairment is a disability, whether a reasonable accommodation can be made for the individual’s impairment such that, with the reasonable accommodation, the impaired individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;

3.30.4.4. Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable
accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital’s operations or the provision of patient care; and,

3.30.4.5. Whether the impairment could negatively impact the quality of care or the health or safety of the impaired individual, patients, Hospital employees, physicians or others within the Hospital;

3.30.4.6. If the Committee determines that there is a reasonable accommodation that ensures patient safety, the Committee shall attempt to work out a voluntary agreement with the impaired individual. The Chief Executive Officer shall be kept informed of the voluntary agreement before it becomes final and effective;

3.30.4.7. If the Committee determines that there is no reasonable accommodation that can be made, or if the Committee cannot reach a voluntary agreement with the impaired individual, the Credentials Committee shall make a recommendation and report to the Board of Trustees through the Medical Executive Committee, as appropriate to the action to be taken. If the Committee’s recommendation would provide the impaired individual with a right to a hearing as described in the Medical Staff Bylaws, the impaired individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Seven of the Medical Staff Bylaws;

3.30.4.8. The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual’s credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the individual’s credentials file and further monitoring or other follow-up shall be at the discretion of the Medical Executive Committee or the Credentials Committee;

3.30.4.9. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws.

3.31. TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES

If it is determined that the individual suffers from an impairment that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

3.31.1. An individual with impairment shall not be reinstated until it is established, to the Medical Staff’s satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological impairment such that the condition is under sufficient control;
3.31.2. The Medical Staff is not required to extend membership or privileges to an individual with an impairment, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual;

3.31.3. Upon sufficient proof that the individual who has been found to be suffering from impairment has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the impaired individual for reinstatement of Medical Staff membership or clinical privileges;

3.31.4. In considering an impaired individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount;

3.31.5. The Medical Staff must first obtain a letter from the physician director of the rehabilitation program where the impaired individual was treated, or the physician directing the impaired individual’s medical or psychological treatment. The impaired individual must authorize the release of this information. The following information shall be requested in providing guidance to the physician director regarding the content of the letter:

3.31.6.1. Whether the impaired individual is participating in the program or treatment;
   3.31.6.1. Whether the impaired individual is in compliance with all of the terms of the program or treatment plan;
   3.31.6.2. Whether the impaired individual attends AA/NA meetings regularly (if appropriate);
   3.31.6.3. To what extent the impaired individual’s behavior and conduct are monitored;
   3.31.6.4. Whether, in the opinion of the treating physician, the impaired individual is rehabilitated or the medical/psychological impairment is under control;
   3.31.6.5. Whether an after-care program has been recommended to the impaired individual (if appropriate), and if so, a description of the after-care program; and,
   3.31.6.6. Whether, in the opinion of the treating physician, the impaired individual is capable of resuming practice and providing continuous, competent care to patients.

3.31.7. The Medical Staff has the right to require opinion(s) from other physician consultants of its choice.

3.31.8. Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:
   3.31.8.1. The impaired individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;
   3.31.8.2. The individual shall be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care
program, or treating physician – for a period of time specified by the Medical Executive Committee stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired;

3.31.8.3. The individual must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the President of the Medical Staff, the Chairperson of the Credentials Committee or the pertinent Department Chairperson;

3.31.8.4. As a condition of reinstatement, the impaired individual’s credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article Three, Section 3.8 of these Bylaws. Minimally, licensure, DEA, state narcotics registration, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the impairment.

3.31.8.5. If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the individual refuses or fails to comply with these procedures, he/she will be subject to a suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual’s contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.

3.31.8.6. If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

3.31.8.7. All requests for information concerning the impaired individual shall be forwarded to the Chief Executive Officer for response. Information concerning an individual seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.

3.32. ACTIONS IN RESPONSE TO DISRUPTIVE CONDUCT

3.32.1. It is the policy of the Hospital for all individuals working in the Hospital to treat others with respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. In dealing with incidents of disruptive conduct
conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Hospital are paramount concerns.

3.32.2. Disruptive conduct or behavior is defined as that which adversely affects or impacts the Hospital operations or the ability of others to get perform their jobs done competently, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital. For the purposes of these Bylaws, examples of “disruptive conduct” include, but are not limited to:

3.32.2.1. Rude or abusive behavior or comments to Hospital personnel, Advanced Practice Professionals, patients, or Practitioners.

3.32.2.2. Negative comments to patients about other Practitioners, nurses or other Hospital personnel or Medical Staff members or about their care and treatment in the Hospital.

3.32.2.3. Verbal attacks, which are personal, irrelevant or go beyond fair, professional conduct, and that are directed to Hospital personnel, Medical Staff, Advanced Practice Professionals, contracted staff, or patients.

3.32.2.4. Irrelevant or inappropriate comments, drawings, or illustrations made in a patient’s medical records or other Hospital business records, impugning the quality of care in the Hospital, or attacking particular Practitioners, Advanced Practice Professionals, nurses, other Hospital personnel, or Hospital policies.

3.32.2.5. Criticism that is addressed to a recipient in such a manner as to that intimidates, undermines confidence, belittles or implies stupidity or incompetence or some other type of public humiliation.

3.32.2.6. Disruption of Hospital operations, Hospital or Medical Staff committee(s) or departmental affairs.

3.32.2.7. Lying, cheating, knowingly making false accusations, altering, or falsifying any patient’s medical records or Hospital documents.

3.32.2.8. Verbal or physical maltreatment of another individual, including physical or sexual assault.

3.32.2.9. Harassment, including words, gestures and actions, verbal or physical, that interferes with a person’s ability to competently perform his or her job.

3.32.2.10. Conduct or behavior that causes a hostile or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation: offensive comments, jokes, innuendos, sexually-oriented statements, printed material, material distributed through electronic media or items posted on walls or bulletin boards. Hostile Work Environment may also be created by conduct or behavior that is directed at a specific person or persons that causes substantial emotional distress.

3.32.2.11. Sexual harassment including conduct or behavior that includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, particularly if:
3.32.11.1. Submission to such conduct is made either explicitly or implicitly a term or condition of employment.

3.32.11.2. Submission to or rejection of such conduct is used as the basis for decisions affecting an individual’s employment.

3.32.11.3. Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive work environment.

3.32.11.4. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.

3.32.11.5. Sexual harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations.

3.32.3. Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospital policy, local and State laws.

3.32.4. An employee who engages in disruptive conduct shall be dealt with in accordance with the Hospital’s Human Resources policies. A Member of the Medical Staff and other individual with clinical privileges who engages in disruptive conduct shall be dealt with in accordance with this Section of the Bylaws. Disruptive conduct resulting from impairment as defined in Section 3.32 of these Bylaws should be dealt with using either 3.31 or 3.32, whichever Section is most appropriate for the conduct in question.

3.32.5. In the event of any apparent or actual conflict between these Bylaws and the Rules and Regulations, policies of the Medical Staff, or other policies, the provisions of these Bylaws shall control.

3.32.6. This section of the Bylaws outlines initial collegial steps (i.e., warnings and meetings with a Practitioner) that may be taken in an attempt to resolve complaints about disruptive conduct exhibited by a Practitioner. However, there may be a single incident of disruptive conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in these Bylaws precludes immediate referral to the Chief Executive Officer, the Medical Executive Committee or to the Board, with the Chief Executive Officer, Medical Executive Committee or the Board implementing immediate actions, which may include but is not limited to summary suspension, the filing of criminal charges, or the elimination of any particular step outlined herein so as to take immediate action in dealing with a complaint regarding disruptive conduct.

3.32.7. Nurses, other Hospital employees, or other individuals who observe, or are subjected to, disruptive conduct by a Practitioner shall notify their supervisor about the incident or, if their supervisor’s behavior is at issue, they shall notify the Chief Executive Officer (or designee). Any Practitioner who observes such
behavior shall notify the Chief Executive Officer directly. Upon learning of the occurrence of an incident of disruptive conduct, the supervisor/Chief Executive Officer shall request that the individual who reported the incident document it in writing. In the alternative, the supervisor/Chief Executive Officer shall document the incident as reported.

3.32.8. The documentation shall, to the extent possible, include:

3.32.8.1. The date and time of the questionable behavior;
3.32.8.2. A factual description of the questionable behavior;
3.32.8.3. The name of any patient or patient’s family members who were involved in the incident, including any patient or family member who witnessed the incident;
3.32.8.4. The circumstances which precipitated the incident;
3.32.8.5. The names of other witnesses to the incident;
3.32.8.6. Consequences, if any, of the disruptive conduct as it relates to patient care, personnel, or Hospital operations; and,
3.32.8.7. Any action taken to intervene in, or remedy, the incident.

3.32.9. The supervisor shall forward a documented report to the Chief Executive Officer, who shall immediately notify the President of the Medical Staff. The Chief Executive Officer and the President of the Medical Staff shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.

3.32.10. If a reporting individual is unwilling or uncomfortable with reporting disruptive conduct using the procedure described in Section 3.31.8, then a report of the incident may be made to the Hospital’s Ethics & Compliance Officer or the Ethics Line at 1-800-455-1996.

3.32.11. After a determination that the incident of disruptive conduct has occurred, the President of the Medical Staff and/or Chief Executive Officer (or their respective designees) shall meet with the Practitioner. If appropriate, this initial meeting should be collegial. During the meeting, the Practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response and/or perspective concerning the incident. The Practitioner shall be advised that, if the incident occurred as reported, his/her conduct was inappropriate and inconsistent with the standards of the Hospital and the Bylaws. The identity of the individual preparing the report of disruptive conduct shall not be disclosed at this time, unless the Chief Executive Officer and President of the Medical Staff agree in advance that it is appropriate to do so. In this case, the Practitioner shall be advised that any retaliation against the person reporting the incident will be grounds for immediate exclusion from all Hospital facilities.

3.32.12. This initial meeting may also be used to educate the Practitioner about administrative channels that are available for registering complaints or concerns about quality or services. Other sources of support or counseling may also be identified for the Practitioner, as appropriate.

3.32.13. The Practitioner shall be advised that a summary of the meeting shall be prepared and a copy provided to him or her. The Practitioner may prepare a written response to the summary. The President of the Medical Staff shall cause the summary and any response that is received to be kept in the confidential portion of the Practitioner’s credentials file. The Chief Executive Officer shall cause the written report(s) of the incident, summary of the meeting, and any
other records regarding the incident or the meeting to be kept as a confidential risk management record.

3.32.14. If another report of disruptive conduct involving the Practitioner is received, a second meeting shall be held. At least three people (e.g., the President of the Medical Staff, the Chairperson of the Credentials Committee, other medical staff leader, and/or the Chief Executive Officer, or legal counsel) shall be present to meet with the Practitioner. At this meeting, the Practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. The Practitioner shall be advised that the matter may be referred to the Medical Executive Committee or to the Board of Trustees for more formal action.

3.32.15. Following this meeting, a letter shall be sent to the Practitioner. The letter shall describe the disruptive conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter should also confirm that the Practitioner could be excluded from all Hospital facilities for a period of time, a request that a formal investigation could be commenced pursuant to the Bylaws, and any other remedies could be taken to adequately protect the patients, hospital staff and others from continued disruptive conduct. The letter will also define the conditions of continued practice at the Hospital. The Practitioner shall be required to sign it. The President of the Medical Staff shall cause records of the second meeting and the letter to the Practitioner to be filed in the confidential portion of the credentials file. The Chief Executive Officer shall cause records of the second meeting and the letter to the Practitioner to be filed in confidential risk management files. If the Practitioner refuses to sign the letter, the Chief Executive Officer and/or the President of the Medical Staff shall request that a formal investigation be commenced pursuant to the Bylaws and the advice of legal counsel should be obtained.

3.32.16. The Medical Executive Committee shall be fully apprised of the previous warnings issued to the Practitioner and the actions taken to address the concerns.

3.32.17. The Medical Executive Committee may, at any point in the investigation, refer the matter to the Board without a recommendation. Any further action, including hearing or appeal, shall then be conducted under the direction of the Board.

3.32.18. When, despite prior warning, the Practitioner continues to engage in disruptive conduct, the Practitioner may be excluded from the Hospital’s facilities and a precautionary suspension imposed during which time an investigation shall be conducted to determine the need for a professional review action. Immediate exclusion and precautionary suspension may also be imposed for a single event when a Practitioner’s conduct is so disruptive that failure to take such action may result in an imminent danger to the health of any individual. Precautonary suspension shall be imposed in accordance with Article Six of these Bylaws.

4. ARTICLE FOUR: CATEGORIES OF THE MEDICAL STAFF

4.1. CATEGORIES

The Staff shall include the categories of Active Staff, Affiliate Staff, Community Membership Staff, and Honorary Recognition. At the time of appointment and at the time

127 Health Care Quality Improvement Act, 42 U.S.C. §11112(c)(1 – 2)
of each reappointment, the Medical Staff Member’s staff category shall be recommended by the Medical Executive Committee and approved by the Board.128

4.2. LIMITATIONS ON PREROGATIVES

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner’s appointment or reappointment, by state or federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.

4.3. ACTIVE STAFF

4.3.1. REQUIREMENTS FOR ACTIVE STAFF

The Active Staff category shall consist of Practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight.129 Members of the Active Staff shall meet the basic qualifications set forth in Article Three. To qualify for the Active Staff category, the Medical Staff Member shall have contributed to fulfilling medical staff functions by completing at least two of the following types of activities during the last term of appointment, as determined by the Department Chairperson and approved by the Board of Trustees, including during provisional status during an initial term of appointment:

- Term of office as a Medical Staff Officer or Department Chairman;
- Membership on the Board of Trustees;
- Medical Staff committee Chairman;
- Medical Staff committee Member;
- Timely response to on-call duties when on-call;
- Serving as a proctor to a practitioner under focused professional practice evaluation;
- Serving as a physician advisor or peer reviewer;
- Timely completion of medical records (e.g., Member had patient admissions and had no delinquencies in completion of their records during term of appointment);
- Serving on a Hospital committee or team/task group;
- Supervisory duties, e.g., serving as the medical director of a Hospital department, or supervision of a Limited Licensure Practitioner;
- Providing education to fellow Medical Staff members, e.g., grand rounds, formal educational presentation, author of a medical staff newsletter article; or,
- Supervising participants in a Hospital-sponsored professional graduate education program.

128 42 C.F.R. §482.22(c)(3)
129 MS.06.01.03, Introduction
4.3.2. **PREROGATIVES OF ACTIVE STAFF**

Members of the Active Staff shall be eligible to vote and hold office within the Medical Staff organization. Any Active Staff Member may attend Medical Staff and department meetings and serve on committees of the Board, Medical Staff or Hospital. Members in the Active Staff category shall compose the group defined as the Organized Medical Staff. Active Staff Members shall:

4.3.2.1. Admit patients without limitations, unless otherwise provided in the Staff Bylaws and Rules and Regulations.

4.3.2.2. Actively participate in the performance improvement activities required of the Staff, in emergency services coverage, and in discharging such other Staff functions as may be required from time to time. After twenty (20) years of local community-wide active service and after the 55th birthday, at the choice of the Medical Staff Member and with approval of the Medical Executive Committee, may be exempted from the ER specialty call, notwithstanding any other obligations as outlined in the Medical Staff Bylaws.

(Practitioners who are within five (5) years of achieving ED Call exempt status at the time of this Bylaws revision, September 24, 2013, will have the right to appeal to the Medical Executive Committee for exemption under the previous rules (ten (10) years). All appeals must be initiated on or before January 1, 2015.

4.3.3. **OBLIGATIONS OF ACTIVE STAFF**

Each Member of the Active Staff shall discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her Medical Staff Department or Division as specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; attend Medical Staff and Department meetings; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations including any future changes to these Bylaws or Rules and Regulations, and comply with directives issued by the Medical Executive Committee.

4.4. **AFFILIATE STAFF**

4.4.1. **REQUIREMENTS FOR AFFILIATE STAFF**

4.4.1.1. The Affiliate Staff category shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital for consultation, call coverage, referral of patients, or other patient care purposes. The Affiliate Staff shall consist of practitioners, each of whom:

---

130 42 C.F.R. §482.55(b)(2)
• Meets the basic qualifications set forth in Article Three.
• Are allowed 11 elective encounters per year with those encounters occurring during ER call rotation excluded.
• May be required to participate in ER Call Coverage as deemed necessary by the Medical Executive Committee.
• If at any time during the staff year, an Affiliate member exceeds 11 patient encounters, he/she will automatically be placed on the Active Staff. The practitioner will then be required to fulfill all responsibilities of the Active Staff as defined in Section 4.3.2.

4.4.2. PREROGATIVES OF AFFILIATE STAFF

Members of the Affiliate Staff shall not be eligible to vote or hold office within the Medical Staff organization. An Affiliate Staff Member may serve on committees of the Medical Staff or Hospital and may attend Medical Staff and Department meetings. Affiliate Staff members completing at least two of the activities required for Active Staff during a current term of appointment may request advancement to the Active Staff category.

4.4.3. OBLIGATIONS OF AFFILIATE STAFF

Each Member of the Affiliate Staff shall discharge the basic obligations of staff members as required in these Bylaws; accept emergency on-call coverage for emergency care services within his/her clinical specialty as may be specified by the requirements of the assigned Medical Staff Department131; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations.

4.5. COMMUNITY MEMBERSHIP STAFF

4.5.1. REQUIREMENTS FOR COMMUNITY MEMBERSHIP STAFF

The Community Membership Staff category shall consist of Practitioners who do not practice in the Hospital but still desire to maintain medical staff appointment to provide continuity of care to their patients or to satisfy a criterion of medical staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s). The Community Membership Staff category is a membership-only category of the Medical Staff with no clinical privileges, and limited medical staff responsibilities and prerogatives. As Members of the Medical Staff, Community Membership Staff shall be fully credentialed and shall be granted membership based on a recommendation by the Medical Staff, with approval by the Governing Body. Since no clinical privileges are granted, Community Membership Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

4.5.2. PREROGATIVES OF COMMUNITY MEMBERSHIP STAFF

Members of the Community Membership Staff may visit their hospitalized patients, and review their patients’ medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures.

131 42 C.F.R. §482.55(b)(2)
Community Membership Staff shall not be eligible to vote or hold office within the Medical Staff organization.

4.5.3. OBLIGATIONS OF COMMUNITY MEMBERSHIP STAFF

Each Member of the Community Membership Staff shall discharge the basic obligations of staff members as required in these Bylaws; but they shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required. Each Member of the Community Membership Staff shall establish appropriate referral and coverage arrangements with an Active or Affiliate Staff Member for the medical care of his/her patients that require Hospital services.

4.6 HONORARY RECOGNITION

4.6.1. REQUIREMENTS FOR HONORARY RECOGNITION

Honorary Recognition shall be granted to Practitioners retired from professional practice who are recognized for their noteworthy contributions to the health and medical sciences, or previous long-standing service to the Hospital. Due to being retired, Practitioners with Honorary Recognition are not eligible for Medical Staff membership or clinical privileges, and therefore shall not be subject to any credentialing process.

4.6.2. PREROGATIVES OF HONORARY RECOGNITION

Practitioners with Honorary Recognition shall be invited and welcome to attend educational and social functions of the Hospital and Medical Staff.

4.7. CHANGE IN STAFF CATEGORY

Pursuant to a request by the Medical Staff Member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in medical staff category of a Member consistent with the requirements of the Bylaws. The Board shall approve any change in category.

4.8. MEDICAL STUDENTS, INTERNS, EXTERNS, RESIDENTS, AND FELLOWS

The terms, “medical students,” “interns,” “externs,” “residents,” and “fellows,” (hereinafter referred to collectively as “house staff”) as used in these Bylaws, refer to Practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and the Board, and who, as part of their educational program, will provide health care services at the Hospital. House staff shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. House staff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or program; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their supervisory function. The school or program shall provide a written description of the role, responsibilities, and patient care activities of participants in the training program. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a house staff Practitioner to provide services at this Hospital. House staff Practitioners may render patient care services at the Hospital only pursuant to and limited by the following:

132 MS.04.01.01
4.8.1. House staff Practitioners who have completed the basic level of training for licensure shall be licensed in this State and shall be limited by applicable provisions of the professional licensure requirements of this State;

4.8.2. A written affiliation agreement between the Hospital and the sponsoring medical school or training program; such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for a house staff Practitioner, in the amount of $1 million for each claim and $3 million in aggregate or other demonstration of insurance as approved by the Facility; and,

4.8.3. The protocols or policies established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program regarding the scope of a house staff Practitioner’s authority (e.g., authority and circumstances under which they may write patient care orders and make entries in the patient record, subject to supervision and countersignature by a supervising LIP), mechanisms for the direction and supervision of a house staff Practitioner (e.g., mechanisms for the supervising LIP and the school’s program director to make decisions about each house staff Practitioner’s progressive involvement and independence in specific patient care activities), and other conditions imposed upon a house staff Practitioner by this Hospital or the Medical Staff.  

4.8.4. While functioning in the Hospital, house staff Practitioners shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the Chief Executive Officer or the President of the Medical Staff. House staff Practitioners may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. A house staff Practitioner shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. House staff Practitioners may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Divisions, or committees, but shall have no voting rights.

4.8.5. The Medical Education Committee or their designee shall be responsible for overseeing house staff Practitioners and shall communicate to the Medical Executive Committee and the Board about the patient care provided by, and the related educational and supervisory needs of, the participants in the professional graduate education programs, including demonstrated compliance with any residency review committee citations as applicable to the program.

4.8.6. As defined in Section 4.8 above, house staff Practitioners are distinguished from Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g., “moonlighting” or locum tenens coverage) and not as part of their educational program. Such Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in these Bylaws and shall be subject to the credentialing procedures specified in

---

133 MS.04.01.01
134 MS.04.01.01
these Bylaws in the same manner as a Practitioner seeking appointment to the Medical Staff.

4.9. ADVANCED PRACTICE PROFESSIONALS

The term, “Advanced Practice Professional” (APP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories of APPs eligible for clinical privileges shall be approved by the Board and shall be credentialed through the same processes as a Medical Staff Member, as described in Article Three, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although APPs are credentialed as provided in these Bylaws, in Article Three, they are not eligible for Medical Staff membership. They may provide patient care services only to the extent of the clinical privileges that have been granted. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), and advanced registered nurse practitioners (ARNP),\(^\text{135}\).

4.9.1. REQUIREMENTS FOR ADVANCED PRACTICE PROFESSIONALS

As permitted by state law, APPs shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. The terms of the accountability of the APP to the Medical Staff Member and the terms for supervision of the APP by a Medical Staff Member shall be documented in a sponsorship agreement between the APP and the sponsoring Medical Staff Member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for clinical privileges shall contain all of the following information:

4.9.1.1. Name of the sponsoring Medical Staff Member and name of any alternative sponsoring Medical Staff members;

4.9.1.2. Completed sponsoring Medical Staff Member’s evaluation;

4.9.1.3. Requested clinical privileges shall specify the degree of supervision required for the performance of each clinical privilege, and shall be signed by the sponsoring Medical Staff Member(s);

4.9.1.4. Signed agreement by the sponsoring Medical Staff Member(s) to provide required supervision and accept responsibility for the patient care services provided by the APP.

4.9.2. PREROGATIVES OF ADVANCED PRACTICE PROFESSIONALS

APPs shall not be eligible to vote, or hold office within the Medical Staff organization. An APP may attend Medical Staff or Department/Division meetings if invited.

4.9.3. OBLIGATIONS OF ADVANCED PRACTICE PROFESSIONALS

Each APP shall discharge the basic obligations of Staff members as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical

\(^{135}\) 42 C.F.R. §482.12(a)(1)
Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

5.  ARTICLE FIVE: CLINICAL PRIVILEGES

5.1.  EXERCISE OF PRIVILEGES

5.1.1.  Every Practitioner or Advanced Practice Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in Sections 5.3 and 5.4 below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board.¹³⁶ The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this State or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual’s current competence, and shall be subject to the Rules and Regulations of the Department or Division.

5.1.2.  Clinical privileges may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws.

5.1.3.  Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient.¹³⁷ Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department/Division Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.¹³⁸

5.2.  QUALIFICATIONS FOR PRIVILEGES

5.2.1.  Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article Three of these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating an applicant who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the applicant does not practice outside the scope of privileges granted, and information about the applicant’s change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted.¹³⁹ The delineation of an individual’s privileges shall include the limitations, if any, on the individual’s privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.¹⁴⁰

5.2.2.  There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of

¹³⁶ MS.03.01.01, MS.03.01.03, MS.06.01.07
¹³⁷ MS.03.01.03
¹³⁸ MS.03.01.03
¹³⁹ MS.06.01.07, MS.08.01.03
¹⁴⁰ MS.06.01.07; MS.08.01.03
current competence and ability to perform the privileges requested. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients. Clinical privileges that are granted, renewed, or revised shall be appropriate to the scope of services and service capabilities of the Hospital, meaning that in approving privileges, considerations shall include not only the applicant’s qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Board of Trustees to only certain settings within the Hospital, as appropriate to each setting.

5.2.3. The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of ongoing professional practice evaluation, as provided for in the Medical Staff’s Professional Practice Evaluation Policy. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges, and the applicant’s participation in continuing education shall be considered when renewing or revising such privileges. Before clinical privileges are granted, renewed, or revised by the Board of Trustees, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:

5.2.3.1. For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of record, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about compliance with accepted performance standards and outcomes of the procedures;

---

141 MS.06.01.05
142 MS.06.01.05
143 MS.01.01.01, MS.06.01.01
144 MS.06.01.01, MS.06.01.07
145 MS.05.01.03, MS.08.01.03
146 MS.12.01.01
147 MS.12.01.01
148 MS.06.01.03, MS.06.01.07MS.08.01.03
5.2.3.2. For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;

5.2.3.3. The applicant’s clinical judgment and technical skills;

5.2.3.4. Any evidence of unusual patterns of, or an excessive number of, professional liability claims or legal actions resulting in voluntary settlement(s) or final judgment(s) against the applicant;

5.2.3.5. Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;

5.2.3.6. Relevant Practitioner-specific data that are compared to aggregate data available from specialty specific organizations such as the Society of Thoracic Surgeons (STS) or the American College of Cardiology (ACC);

5.2.3.7. Morbidity and mortality data, when available;

5.2.3.8. Practitioner’s use of consultants;

5.2.3.9. Practitioner’s performance relative to approved standards of practice, patient care protocols, and evidence-based clinical practice guidelines, including but not limited to compliance with core measures protocols.

5.2.4. The information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including the consulting physicians, assistants at surgery, nursing and administrative personnel. Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board of Trustees may, in its discretion, obtain assistance with their evaluation, as provided for in Article Three, Section 3.22 of these Bylaws.

5.3. REQUEST FOR PRIVILEGES

Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Every application for appointment and reappointment, with the exception of Community Members, must contain a request for the specific clinical privileges desired by the applicant. An application for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Staff membership. An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Staff appointment, as provided in Article Three, Section 3.6. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the criteria for each privilege will be processed through the application process. Pursuant to Section 3.8.3, the responsibility for producing a complete application and request for clinical privileges shall be the applicant’s.

5.3.1. ADMITTING PRIVILEGES

149 MS.08.01.03
Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.150

5.3.2. MEDICAL HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.151 A medical history and physical examination shall be completed and documented for each patient no more than 30 days before; or 24 hours after admission or registration, but prior to surgery or a procedure requiring conscious sedation or anesthesia.152 An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

5.3.3. ADDITIONS TO OR INCREASES IN CLINICAL PRIVILEGES

5.3.3.1. A request by an individual with membership or clinical privileges for additional clinical privileges or an increase in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:

5.3.3.1.1. any additional license, certification or registration required for the new clinical privileges or increased clinical privileges requested shall be verified;153

5.3.3.1.2. training, continuing education, and experience related to the new clinical privileges or increased clinical privileges requested shall be verified;154

5.3.3.1.3. evidence of current competence related to the new clinical privileges or increased clinical privileges requested shall be verified. This shall include a review of relevant practitioner-specific performance data when available;155

5.3.3.1.4. an evaluation provided by peers of the applicant shall be included in deliberations when adding or

150 MS.03.01.01; MS.06.01.07, MS.06.01.13
151 MS.01.01.01, 42 C.F.R.§482.22(c)(5)(i)
152 42 C.F.R.§482.22(c)(5)(i)
153 MS.06.01.05
154 MS.12.01.01
155 MS.06.01.05
increasing privileges. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism;\textsuperscript{156}

5.3.3.1.5. applicants are required to report malpractice insurance coverage information for the new privileges or increased clinical privileges requested, and claims history shall be evaluated to determine any evidence of an unusual pattern or excessive number of claims;\textsuperscript{157}

5.3.3.1.6. the Credentialing Processing Center shall query the National Practitioner Data Bank (NPDB) when new clinical privileges or increased clinical privileges are requested;\textsuperscript{158}

5.3.3.1.7. when adding or increasing clinical privileges the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges being requested and health status shall be verified;\textsuperscript{159}

5.3.3.1.8. when adding or increasing clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:

5.3.3.1.8.1. previously successful or currently pending challenges, or voluntary or involuntary relinquishment, of licensure or registration;\textsuperscript{160}

5.3.3.1.8.2. voluntary or involuntary reduction in privileges or termination of privileges or membership;\textsuperscript{161}

5.3.3.1.8.3. involvement in any liability actions, including any final judgments or settlements.

Determination of a change in clinical privileges shall be based on a Practitioner’s subsequent training, experience, and demonstrated competence. A review of each Practitioner’s documented professional training and focused professional practice evaluation will be included in the review of such Practitioner’s request for a change in privileges. A Practitioner who desires a change in his or her clinical privileges in any department shall make a written request to the Chief Executive Officer. The CPC will process the request by performing verifications of training and/or experience and other queries as outlined in this Section 3.10. The Chief Executive Officer will then submit the Practitioner’s written request and any related information to the Chairperson of

\textsuperscript{156} MS.06.01.05
\textsuperscript{157} MS.06.01.05
\textsuperscript{158} MS.06.01.05; 42 U.S.C. §11135, C.F.R. §60.10
\textsuperscript{159} MS.06.01.05
\textsuperscript{160} MS.06.01.05
\textsuperscript{161} MS.06.01.05
the appropriate department for recommendation. The request and the recommendation of the Chairperson of the appropriate department will then be forwarded to the Credentials Committee. The Credentials Committee shall consider the request and will then report recommendations to the Medical Executive Committee. The written comments of the Medical Executive Committee, if any, will be forwarded to the Board of Trustees. Should the Credentials Committee or the Medical Executive Committee make a proposed recommendation against the requested change, the proposed recommendation will be forwarded to the Chief Executive Officer who will notify the Practitioner of the proposed adverse recommendation and of the right to a hearing in accordance with the Fair Hearing Procedure. Such notification will be made prior to forwarding the proposed adverse recommendation to the Board of Trustees. No Practitioner may seek clinical privileges previously requested and denied unless supported by additional training and/or experience.162

5.3.4 PRIVILEGES TO SUPPORT POST-RESIDENCY/FELLOWSHIP SURGICAL TRAINING

To support the introduction of a new procedure or new technology at the Hospital, the Board of Trustees shall determine the appropriateness of the Hospital as a training site, based on whether the Hospital has the resources necessary to support a request to conduct training, such as sufficient space, equipment, staffing, and financial resources, and whether the new procedure or new technology or the offer of training for the procedure/technology fits within the Hospital’s operational planning and is appropriate for the Hospital’s patient population.163 Training shall not be conducted until first approved by the Board of Trustees based on a recommendation from the Medical Executive Committee. The preceptor/trainer and the preceptee/trainee shall be credentialed as described in Article Three of these Bylaws to verify the qualifications necessary for these roles. Clinical privileges shall be specifically delineated for the role in which the individual shall serve, and the new procedure or new technology to be taught. The preceptor/trainer and the preceptee/trainee shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, specifically including any relevant requirements related to patient rights, informed consent, and if applicable, requirements related to the conduct of research. After completion of training, the preceptee/trainee may be eligible to request clinical privileges for the new procedure or new technology, provided that competency in the privilege has been validated. For purposes of this Section, the following definitions shall apply:

5.3.4.1. Preceptor/trainer: An expert surgeon/physician who undertakes to impart his or her clinical knowledge and skills in a defined setting to a preceptee. The preceptor must be appropriately privileged, skilled, and experienced in the procedure(s) and or technique(s) in question. To serve as a preceptor in a specific procedure or technique, the surgeon physician (preceptor) must be a recognized authority (e.g., through publications, presentations, extensive clinical experience) in the particular field of expertise.

5.3.4.2. Preceptee/trainee: A surgeon/physician with appropriate basic knowledge and experience seeking individual training in skills and/or


163 MS.06.01.01
procedures not learned in prior formal training. The trainee must have appropriate background knowledge, basic skills, and clinical experience relevant to the proposed curriculum. The trainee should be board-eligible as defined in these Bylaws or certified in the appropriate specialty or possess equivalent board certification from outside the United States.

5.3.5 LOCUM TENENS PRIVILEGES

Clinical privileges may be granted to a Practitioner qualified as described in Article Three, Section 3.1, who plans to practice within the Hospital on an intermittent or substitute basis. Unless requested, a locum tenens Practitioner shall not be granted medical staff membership. The locum tenens Practitioner shall be credentialed as described in Article Three, and if qualified may be granted requested delineated clinical privileges for a period limited to the time during which the Practitioner is serving as a substitute for a Medical Staff Member, or for the time of intermittent coverage, but in no case shall the term of privileges be greater than two years from the date the clinical privileges were approved. The locum tenens Practitioner may be eligible for temporary privileges in accordance with Section 5.4 of these Bylaws. The locum tenens Practitioner shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, including requirements for focused professional practice evaluation and ongoing professional practice evaluation, and rights to a fair hearing.

5.3.6 NEW/TRANSPECIALTY PRIVILEGES

Prior to accepting request of a privilege, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame. Hospital leaders shall determine whether sufficient space, equipment, staffing, and financial resources are in place or will be available within a specified time frame to support each privilege. The clinical privileges available for request shall be approved by the Board of Trustees, based on this determination of hospital leaders. Any request for clinical privileges that are either new to the Hospital or that overlaps more than one Department shall review the need for, and appropriateness of a new procedure or service. The Credentials Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transspecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege. In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Departments or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature or specialty associations. In addition to establishing privileging criteria, the Credentials Committee may consider the need for development of policies related to call coverage, cross coverage, manner of handling clinical complications, and any other clinical policies that may be needed in association with new or transspecialty privileges. The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board shall be based in part on whether the new procedure or service is appropriate to the Hospital.

164 MS.06.01.01
165 MS.01.01.01; LD.01.05.01
5.3.7. TELEMEDICINE PRIVILEGES

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions. In addition to meeting all other qualification for clinical privileges, the following credentialing procedures shall be followed:

5.3.7.1. When a telemedicine provider is providing services from a different State, licensure will be verified for both the State where the hospital is located and the State where the practitioner is located.

5.3.7.2. Specific to telemedicine providers, due to extraordinary high number of healthcare affiliations, queries will be limited to the top five high volume affiliations and any healthcare organization from which the practitioner was reassigned during the last five years.

5.3.8. DISCONTINUING A SERVICE

As part of the process for ongoing evaluation and planning of patient care services, the Board of Trustees may determine that a particular patient care service shall be discontinued. In the event that a patient care service is discontinued the Board of Trustees shall retract the clinical privileges associated with the provision of those services and notify the affected Practitioners and APPs of the clinical privileges that have been retracted as of a specified effective date. Clinical privileges shall be retracted due to changes in the services provided by the Hospital, and retraction of clinical privileges shall not be considered an adverse action, therefore, there shall be no right to hearing and appeal in association with decisions to change the services offered by Hospital.

5.3.9. USE OF OUTPATIENT ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS AND APPS

A Practitioner who is not a Medical Staff Member and who has not been granted clinical privileges may order outpatient ancillary services and the Hospital may accept and execute orders for outpatient ancillary services from Practitioners who are not members of the Medical Staff and who have not been granted any clinical privileges at the Hospital only if all the following conditions are met:

5.3.9.1 Non-privileged practitioners and non-privileged APPs may refer patients and order outpatient ancillary services only if the Practitioner or APP is:

5.3.9.1.1 Responsible for the care of the patient;

---

166 MS.13.01.01
167 MS.13.01.01 – MS.13.01.03
168 MS.13.01.01 – MS.13.01.03
169 42 C.F.R. §482.26(c)(1), Interpretive Guidelines
170 MS.06.01.07
5.3.9.1.2. Licensed in, or holds a license recognized in the jurisdiction where he/she sees the patient;

5.3.9.1.3. Acts within his/her scope of practice under state law;

5.3.9.1.4. Is not an Ineligible Person; and

5.3.9.1.5. Is authorized by the Medical Staff to order the applicable outpatient services under written Hospital policy that is approved by the Board of Trustees of the Hospital.

5.3.9.2. If medications are being ordered, the Practitioner shall provide proof of current, unrestricted DEA registration.

5.3.9.3. The Hospital shall ensure that the Practitioner is eligible to participate in Federal and State Health Programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and the exclusion lists shall be rechecked according to the frequencies defined by hospital policy;171

5.3.9.4. The Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order, as established by State law. The orders shall be confined to those for outpatient laboratory, non-invasive radiology, rehabilitation services (including physical therapy, occupational therapy, and speech therapy), diagnostic cardiopulmonary or electrodiagnostic testing.

5.3.9.5. The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional.

5.3.9.6. The ordering professional does not hold himself to be associated or affiliated with the Hospital or its Medical Staff.

5.3.9.7. The Practitioner’s ordering practices shall be subject to the supervision of the medical director of the Hospital department performing the test or service, or the President of the Medical Staff. The Practitioner’s ordering practices shall be subject to a review for medical appropriateness and necessity. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the Practitioner or non-privileged APP shall be notified immediately to be given the opportunity to clarify/justify the order. The patient will be informed of the reasons why the test cannot be performed and instructed to call his/her Practitioner. The patient may be given a Patient Information Pamphlet.

5.3.9.8. All diagnostic tests that require an interpretation by a Practitioner with a delineated clinical privilege to do so shall be subject to interpretation by a Member of the Medical Staff with such privileges and the interpretation shall be provided to the non-privileged Practitioner or non-privileged APP.

5.3.9.9. Out-of-state non-privileged Practitioners may be allowed to refer patients and order outpatient ancillary services without having a license to practice in the State in which the facility is located provided the State’s professional licensure agency allows an exception.

---

171 HCA, Ethics & Compliance Policy QM.002
5.3.10 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall not be processed and the individual shall be informed that the privilege is not available and such refusal to process a request shall not be subject to the fair hearing rights under these Bylaws or to reporting.

5.4 TEMPORARY PRIVILEGES

Temporary clinical privileges constitute temporary permission to attend patients at the Hospital. Temporary clinical privileges are distinguished from other privileges of the Hospital in that they are not based upon complete review of credentials and are granted or revoked by the Chief Executive Officer after consultation of the President of the Medical Staff or his or her designee. Temporary clinical privileges may be granted only for a specific period of time, not to exceed 120 days, and shall automatically expire at the end of the specified period, without recourse by the Practitioner under the Fair Hearing Procedure. Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws or to Advanced Practice Professionals as defined in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff or currently privileged Advanced Practice Professionals, or when a new applicant with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and Board of Trustees. Therefore, temporary privileges shall be granted only rarely. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner or Advanced Practice Professionals exercising such privileges. A Practitioner or Advanced Practice Professionals shall not be entitled to the procedural rights of fair hearing or appeal afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any revocation of temporary privileges, unless the revocation is based on questions of clinical competency or professional conduct.

5.4.1 QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this State, a current and unrestricted DEA registration reflecting an in-state address for the State of Florida, and (if the practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, documentation of professional liability insurance coverage as required by the Board except as specified in Section 5.3.2.3 in this Article, and for Practitioners a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care. Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source, and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant’s status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall

---

172 Federal Register, Volume 71, No. 231, Friday, 12/1/2006, Page 69478 – 69480, Clarification of Registration Requirements for Individual Practitioners
173 MS.06.01.13
174 42 C.F.R §412.46(c)
175 MS.06.01.03
176 HCA, Ethics & Compliance Policy QM.002
check the OIG Sanction Report, and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies. Individuals who are granted temporary privileges will be subject to the Hospital’s policy regarding focused professional practice evaluation (FPPE). Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

5.4.2. CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer upon receiving a recommendation from the appropriate Department Chairperson or President of the Medical Staff under the conditions noted below. Individuals practicing based on temporary privileges shall be acting under the supervision of the Chairperson of the Department to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below. During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by hospital policy. Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients. A request for temporary privileges shall be made in writing, on forms approved for that purpose by the Hospital.

5.4.2.1. Pendency of Application: After receipt of complete application for Medical Staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Article Five, Section 5.4.1 may be granted temporary while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days. An applicant waiting for processing of an application for Medical Staff membership shall be eligible for temporary privileges only after submitting a complete application and only under the following conditions:

5.4.2.1.1. There are no current or previously successful challenges to licensure or registration;
5.4.2.1.2. There are no adverse membership actions at another hospital; and,
5.4.2.1.3. There are no adverse actions against the applicant’s privileges at another hospital.

177 MS.06.01.13
178 MS.06.01.13
179 HCA, Ethics & Compliance Policy QM.002
180 MS.06.01.07, MS.08.01.03
181 MS.06.01.13
182 MS.06.01.13
5.4.2.2. **Care of Specific Patient(s):** Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein. After receipt of a written request for temporary privileges, a Practitioner or Advanced Practice Professionals qualified as described in Article Five, Section 5.4.1 may be granted temporary privileges if the Practitioner or Advanced Practice Professionals has a specific skill not possessed by a privileged Practitioner or Advanced Practice Professionals and the specific skill is needed by a specific patient or specific group of patients, authorization may be granted to provide care for that specific patient or group of patients. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient(s) or one hundred and twenty (120) consecutive days, whichever is less. A Practitioner or Advanced Practice Professionals may be granted temporary privileges under this condition for no more than two instances in a twelve-month period. After a Practitioner or Advanced Practice Professionals has been granted temporary privileges under this condition for the second instance within twelve months, he/she shall be invited to apply for Medical Staff membership and/or clinical privileges.

5.4.2.3. **Disaster Response and Recovery:** Potential disaster situations shall be described in the Hospital Emergency Management Plan and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster. Upon activation of the Hospital’s Emergency Management Plan and in a situation in which the Hospital is not able to meet immediate patient needs, temporary disaster privileges may be granted to an appropriately qualified Practitioner as described in Article Five, Section 5.4.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Management Plan (EMP), upon recommendation by the President of the Medical Staff or the EMP designated Medical Staff Director. All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designee, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs. Approvals shall be documented in writing. The President of the Medical Staff or the EMP designated Medical Staff Director shall also assign a Member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges, through direct observation, mentoring, or clinical record review. Practitioners who are employees of any Federal agency, and

---

183 MS.06.01.13  
184 EM.02.02.13  
185 EM.02.01.01  
186 EM.02.02.13  
187 EM.02.02.13  
188 EM.02.02.13  
189 EM.02.02.13
Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less. In the event that the disaster creates extreme urgencies as defined in Section 5.4, a Practitioner would be permitted to provide patient care using emergency privileges.

5.4.2.3.1. Temporary disaster privileges may be granted upon presentation of a government-issued photo identification and any of the following, and the qualifications required in Section 5.4.1 of this Article shall be verified as soon as the immediate disaster situation is under control, using a process identical to granting temporary privileges for an immediate patient care need, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the organization, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours.

5.4.2.3.2. A current picture hospital ID card from a healthcare organization with a legible photo and that clearly identifies professional designation;

5.4.2.3.3. A current license to practice in the State of Florida;

5.4.2.3.4. Primary source verification of the license;

5.4.2.3.5. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group;

5.4.2.3.6. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,

5.4.2.3.7. Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the volunteer practitioner’s/APP’s identity and ability to act as a Licensed Independent Practitioner during a disaster.

190 28 U.S.C. §2671; 42 U.S.C. §233(a),(g)
191 MS.06.01.13
192 EM.02.02.13
193 EM.02.02.13
5.4.2.4. The following order of preference should be used in granting temporary disaster privileges:

5.4.2.4.1. Expert from government agencies and medical staff members from other HCA hospitals;

5.4.2.4.2. Volunteers sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or medical staff Member(s) with personal knowledge regarding the practitioner’s APPs identity;

5.4.2.4.2. Volunteers from the community or surrounding areas.

5.4.2.4.3. If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.

5.4.2.4.4. Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff Member if possible, with whom to collaborate in the care of disaster victims.

5.4.2.4.5. The Medical Staff shall oversee the professional practice of volunteer Practitioners either by the direct observation or mentoring provided by the Medical Staff Member assigned to the volunteer Practitioner or when a Medical Staff Member is not available to be assigned, then by medical record review to be performed as designated by the President of the Medical Staff or MEC.

5.4.2.4.6. The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted.

NOTE: In extraordinary circumstances that primary source verification of licensure, certification or registration (if required by law and regulation to practice a profession) cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance there must be documentation of the following:

- Why primary source verification could not be performed in the required time frame;
- Evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and
- An attempt to rectify the situation as soon as possible.

---

194 EM.02.02.13
195 EM.02.02.13
196 EM.02.02.13
Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EMP, upon recommendation by the President of the Medical Staff or the EMP designated Medical Staff Director. In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.

5.4.3. DENIAL, REDUCTION OR TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

5.4.3.1. The CEO may, at any time after consulting with the Chief of the Medical Staff, the Chair of the Credentials Committee, or the Department chair, deny, reduce or terminate temporary clinical privileges.

5.4.3.2. Denial, termination or reduction of temporary privileges shall not constitute grounds for a hearing, and the termination shall take effect without hearing or appeal.

5.5 EMERGENCY PRIVILEGES

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff Member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6. ARTICLE SIX: CORRECTIVE ACTIONS

6.1 INFORMAL INQUIRIES

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical, (3) unprofessional, inappropriate, disruptive or harassing, (as defined in these Bylaws and in Hospital policies, including sexual harassment), (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below applicable professional standards, the Chief of Staff, appropriate Department Chairperson, Credentials Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is

197 EM.02.02.13
198 HCA Ethics & Compliance Policies
199 HCA Ethics & Compliance Policies
credible. A determination will then be made as to whether to refer the matter to the Medical Executive Committee or to deal with the matter in accordance with the relevant Medical Staff policy. If it is determined to direct the matter to the Medical Executive Committee, a written request for investigation shall be prepared, making specific reference to the performance information, activity or conduct that gave rise to the request. The investigation shall be conducted pursuant to the peer review provisions in these Bylaws.  

6.2 ALTERNATIVES TO CORRECTIVE ACTION

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws. Alternatives to corrective action may include:

6.2.1 Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.18 that may be taken to address disruptive conduct;

6.2.2 Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

6.2.3 Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

6.2.4 Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;

6.2.5 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,

6.2.6 Requirements to seek assistance for impairment, as provided in these Bylaws.

6.3 PRECAUTIONARY SUSPENSION OR PRECAUTIONARY RESTRICTION OF CLINICAL PRIVILEGES

6.3.1 Grounds for Precautionary Suspension or Restriction:

Whenever there are reasonable grounds to believe that the conduct or activities of a Practitioner or other individual with clinical privileges poses a threat to the life, health or safety of any patient, employee, or other person present at the Hospital and that, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the Chief of Staff, the chief of a clinical department, the Chief Executive Officer, the Board Chairperson, or the Medical Executive Committee shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation and (3) restrict access to the Hospital by the suspended Practitioner or other suspended individual with clinical privileges.

6.3.1.1 A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

200 MS.01.01.01
201 MS.11.01.01
6.3.1.2 Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

6.3.1.3 A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the Chief of Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee. The Department Chairperson for the Department to which a suspended or restricted Practitioner is assigned shall be responsible for arranging appropriate medical coverage for any of the Practitioner’s patients hospitalized at the time of the suspension or restriction. The wishes of each patient shall be considered, when feasible, in choosing a substitute Practitioner. A suspended or restricted Practitioner’s elective admissions and procedures shall be rescheduled pending reinstatement or reassigned to another Practitioner as requested by each patient.

6.3.1.4 See Article Seven, 7.2.8 regarding hearing rights for individuals who are subject to an adverse recommendation or action.

6.3.2 Medical Executive Committee Procedure:

6.3.2.1 The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

6.3.2.2 After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

6.3.2.3 If the Medical Executive Committee’s recommendation is not adverse to the Practitioner as defined in Article Six of these Bylaws, the Practitioner shall not be entitled to a hearing and appeal.

6.3.2.4 If the Medical Executive Committee’s recommendation is adverse to the Practitioner as defined in Article Six of these Bylaws, the Practitioner shall be afforded procedural rights to an appellate review as outlined in Article Six of these Bylaws. The terms of the suspension shall remain in effect pending a decision by the Board of Trustees.

6.3.2.5 There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.4 FORMAL INVESTIGATION

The Chief Executive Officer shall consult with the President of the Medical Staff, or the Medical Executive Committee to determine whether a concern about professional competence or conduct should be formally investigated. Whenever it appears that corrective action against a Practitioner or other individual with clinical privileges may be
necessary or advisable, the Chief Executive Officer may initiate an investigation by an ad hoc investigation committee. Requests for a formal investigation may be initiated by the Chief Executive Officer, the President of the Medical Staff, by any other officer of the Medical Staff, by the Chairman of any department, by the Chairman of any committee of the Medical Staff, or by any member of the Board of Trustees. Any request for a formal investigation shall be in writing and shall be submitted to the Chief Executive Officer, together with detailed information concerning the specific activities or conduct which constitutes grounds for the request. The initiation of a formal investigation shall not preclude the imposition of suspension or restriction of clinical privileges under Section 5.3 of these Bylaws. A formal investigation shall begin only after a determination by the Medical Executive Committee or the Board of Trustees to do so.

6.4.1. APPOINTMENT OF AD HOC INVESTIGATION COMMITTEE

If a determination is made to investigate formally the necessity or advisability of corrective action against a particular Practitioner, as the result of an informal investigation or otherwise, an Ad Hoc Investigation Committee shall be appointed. In addition, an Ad Hoc Investigation Committee shall be appointed to investigate a Practitioner any time the Licensure Board places a restriction or limitation of any sort on such Practitioner’s license or places such Practitioner on probation, unless the action of the Licensure Board has resulted in automatic termination of the appointment of the Practitioner. It is the explicit intention of the Medical Staff that the Ad Hoc Investigation Committee shall consist of the President of the Medical Staff (or his or her designee), two (2) Practitioners appointed by the Chief Executive Officer and two (2) Practitioners appointed by the President of the Medical Staff. A designee of the Chairperson of the service to which the affected Practitioner is assigned shall serve as a consultant to the Ad Hoc Investigation Committee. The President of the Medical Staff (or his or her designee) shall serve as Chairperson of the Ad Hoc Investigation Committee. The Ad Hoc Investigation Committee shall have no voting members who are in direct economic competition with the Practitioner who is the subject of the investigation. In the event there are not a sufficient number of Practitioners who meet such criteria, the Chief Executive Officer may appoint physicians who are not affiliated with the Hospital who meet such criteria. The Practitioner shall be advised of the names of the Ad Hoc Investigation Committee members within ten (10) days of the appointment of such Ad Hoc Investigation Committee. If the Practitioner who is the subject of the investigation advises the President of the Medical Staff that he or she believes a member of the Ad Hoc Investigation Committee does not meet this criterion, the President of the Medical Staff shall determine the merit of such contention and, if the contention is found to be correct, shall appoint a substitute to serve on the Ad Hoc Investigation Committee. An investigation by an Ad Hoc Investigation Committee shall be considered an administrative matter and not an adversarial proceeding.

6.4.2. Upon conclusion of its investigation, the Ad Hoc Investigation Committee shall submit a report to the Chief Executive Officer and to the Medical Executive Committee. Such report shall contain a statement detailing the findings of the Ad Hoc Investigation Committee. The Medical Executive Committee shall consider the report and make a recommendation to the Board of Trustees.

202 MS.01.01.01
6.5. **ACTION ON INVESTIGATION REPORT**

As soon as practicable after the conclusion of an investigation, the Medical Executive Committee or the Board may:

6.5.1. Determine that corrective action is not warranted and dismiss the matter;

6.5.2. Determine that corrective action is warranted, and use one of the alternatives to corrective action, as described in paragraph 6.2 of these Bylaws; or,

6.5.3. Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article Seven.

6.6. **AUTOMATIC SUSPENSION OR TERMINATION**

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, upon confirmation of the circumstances by the Chief Executive Officer, the individual shall be immediately and automatically suspended from practicing in the Hospital by the Chief Executive Officer, and the individual’s membership may be automatically terminated. The Chief Executive Officer shall notify the individual in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice. The Chief Executive Officer shall also notify the Chief of Staff and Hospital staff members, and take necessary steps to enforce the suspension. The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

6.6.1. **LICENSURE**

If an individual’s license to practice is revoked or suspended by a state licensing authority, or if an individual fails to maintain a current license, he/she shall be immediately automatically suspended from practicing in the Hospital and his/her staff membership shall be automatically terminated.

6.6.2. **CONTROLLED SUBSTANCE REGISTRATION**

If an individual’s DEA or State controlled substance registration is revoked, suspended, or restricted, (i.e., disciplinary action is taken by the DEA or State) he/she may be automatically suspended from practicing in the Hospital. If an individual fails to maintain a current unrestricted registration, (i.e., there is a lapse in renewal or failure to request all schedules needed for the prescribing privileges granted) the individual’s prescribing privileges for the schedule(s) of drugs affected by the restrictions on the DEA or State controlled substance registration shall be immediately automatically suspended.

6.6.3. **LIABILITY INSURANCE**

If an individual’s professional liability insurance is revoked or the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital.

6.6.4. **ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS**

The occurrence of any of the following events shall result in immediate automatic suspension from practicing in the Hospital:

---

203 MS.01.01.01
6.6.4.1. Becoming an Ineligible Person; 204 or,

6.6.4.2. A criminal conviction.

6.6.5. MEDICAL RECORDS

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient’s discharge. When a Medical Staff Member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, following notification, his/her clinical privileges shall be automatically suspended. The suspension shall continue until all of the individual’s delinquent records are completed.

6.6.6. MISREPRESENTATION

Whenever it is discovered that an individual misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, and the misrepresentation or omission is a material or substantive misrepresentation, as judged by the Medical Executive Committee, the individual’s membership and clinical privileges shall be automatically terminated. Substantial or material misrepresentation of the applicant’s qualifications, competence or character may be grounds for the Board of Trustees to permanently disqualify an individual from applying for membership or clinical privileges or to set a specific time period after which the applicant may reapply.

If an individual fails to report to the Hospital any restriction or condition imposed on or probation with respect to his or her license by the licensure board within thirty (30) days of the imposition of such restriction, condition or probation he/she shall be immediately automatically suspended from practicing in the Hospital and his/her Medical Staff membership shall be automatically terminated.

6.7. COVERAGE DURING SUSPENSIONS

When a precautionary suspension or an automatic suspension has been imposed, the Hospital shall arrange for coverage for alternative coverage. When the individual being suspended or restricted is a Practitioner, the Chief of Staff or the Chairperson of the Practitioner’s Department shall arrange for alternative medical coverage of a suspended Practitioner’s patients in the Hospital and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Advanced Practice Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the individual.

6.8. FAILURE TO PROVIDE REQUESTED INFORMATION

Failure of an individual to provide information pertaining to that individual’s qualifications for Medical Staff membership or clinical privileges, or in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information, within the timeframe specified in the written request, will result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

204 HCA, Ethics & Compliance Policy QM.002
6.9. CRIMINAL ARREST OR INDICTMENT

In the event that an individual is arrested for alleged criminal acts, an immediate investigation into the circumstances of the arrest shall be made. The Medical Executive Committee shall review the circumstances leading to the arrest and may determine if further action is warranted prior to the outcome of the legal action. If the Medical Executive Committee recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and appeal as set forth in Article Seven.

6.10. REPORTING REQUIREMENTS

6.10.1. In compliance with the Health Care Quality Improvement Act of 1986, the Hospital shall report to the Board of Medical Examiners in the State of Florida the following actions:

6.10.1.1. Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days;

6.10.1.2. Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist:

6.10.1.3. While the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or

6.10.1.4. In return for not conducting such an investigation or proceeding.

The Hospital may report to the Board of Medical Examiners the actions as described in Sections 5.7.1 and 5.7.2 with respect to other health care practitioners.

6.11. REINSTATEMENT FOLLOWING A SUSPENSION

Requests for reinstatement will be reviewed by the relevant Department chief, the Chair of the Credentials Committee, the President of the Medical Staff, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member or other individual with clinical privileges who has been subject to suspension may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board of Trustees for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board of Trustees for review and recommendation.

6.12. AUTOMATIC RESIGNATION

6.12.1. RELOCATION

Unless otherwise approved by the Board upon recommendation of the Medical Executive Committee, any Member of the staff or other individual with clinical privileges who no longer meets the geographic proximity requirements of the Medical Staff because of relocation of residence or relocation of practice shall be deemed to have automatically resigned from the Medical Staff and automatically relinquished all clinical privileges. Automatic resignation of membership and/or automatic relinquishment of clinical privileges shall not entitle the individual to a fair hearing and appeal.
6.13. FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES

In the event that reappointment or renewal of clinical privileges has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment or privileges, the individual shall be deemed to have automatically resigned from the Medical Staff and automatically relinquished all clinical privileges. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to apply for reappointment and/or renewal of clinical privileges if desired. Automatic resignation of membership and/or automatic relinquishment of clinical privileges shall not entitle the individual to a fair hearing and appeal.

6.14. FAILURE TO BE REINSTATED FOLLOWING AUTOMATIC SUSPENSION

When an individual is automatically suspended due to failure to maintain a current license, a controlled substance registration, liability insurance, or eligibility to participate in Federal Health Care programs, or the automatic suspension is due to failure to complete medical records timely, or any other reason for automatic suspension, and the automatic suspension continues for more than 60 days without verified evidence of reinstatement of the expired credential, reinstatement as a participant in Federal programs, or completion of medical records, then the individual shall be deemed to have voluntarily resigned from the Staff, voluntarily relinquished all clinical privileges, and waived any rights to fair hearing or appeal process. The individual shall be notified of the automatic voluntary resignation and the need to submit a new application if reinstatement of membership or clinical privileges is desired.

7. ARTICLE SEVEN: HEARING AND APPELLATE REVIEW PROCEDURES

7.1 OVERVIEW

Fair hearing and appellate review procedures shall be used when professional review actions are being taken when it involves and individual applying for Medical Staff membership, for an existing Medical Staff Member, and for any other individual applying for or holding clinical privileges. The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Professional review actions are taken when there is a reasonable belief that the action shall be in the furtherance of quality healthcare, and after a reasonable effort to obtain the facts of the matter, and in reasonable belief that the action is warranted by the facts, and after adequate notice and hearing procedures and other procedures as are fair to the individual are afforded to the individual subject to professional review actions. Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified. The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Article Seven, Section 7.10.4 of these Bylaws.

7.2 EXCEPTIONS TO HEARING AND APPEAL RIGHTS

7.2.1. COLLEGIAL INTERVENTION

\[^{205}\text{42 USCS §11112(a)(1) – (4)}\]
\[^{206}\text{MS.10.01.01}\]
An individual does not have a right to a hearing or appeal under Article Six of the Bylaws because of the initiation of an informal inquiry as described in Section 5.1, or when a collegial intervention occurs as defined in Section 5.2, or when an adverse action is recommended but not taken.

7.2.2. AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT
The hearing and appeal rights under these Bylaws do not apply to an individual whose application or request for extension of privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Hospital, or are not granted due to closed staff or exclusive contract or in accord with a Medical Staff development plan. The hearing and appeal rights under these Bylaws do not apply to an individual who has clinical privileges retracted or automatically terminated due to the Hospital closing or discontinuing a service.

7.2.3. MEDICO-ADMINISTRATIVE OFFICER OR OTHER CONTRACT PRACTITIONER
The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. The hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the individual’s contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

7.2.4. AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES
The hearing and appeal rights under these Bylaws do not apply if an individual’s Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws for reasons not related to the Practitioner’s qualifications, competence or professional conduct, as described in Section 6.6.

7.2.5. REMOVAL FROM EMERGENCY CALL PANEL
Participation on the emergency on-call panel is not a benefit or privilege of Staff membership, but rather is an obligation. No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner’s emergency on-call panel obligation(s).

7.2.6. HOSPITAL POLICY DECISION
The hearing and appeal rights of these Bylaws are not available if the Hospital makes a policy decision (e.g., closing a department or service, or a physical plant change) that adversely affects the Staff membership or clinical privileges of any Staff Member or other individual.

7.2.7. HEARING RIGHTS
7.2.7.1. ADMINISTRATIVE ACTIONS

7.2.7.1.1. A Practitioner does not have the right to a hearing in any of the following circumstances:

7.2.7.1.1.1. Change to specific Medical Staff membership prerogatives (as examples: voting privileges, eligibility for committee membership, eligibility to hold office, etc.) if the reasons are unrelated to professional competence or conduct;
7.2.7.1.1.2. Actions taken due to failure to attend meetings as required;

7.2.7.1.1.3. Denial, termination or reduction of temporary privileges;

7.2.7.1.1.4. Denial of reinstatement from a leave of absence if the reasons are unrelated to professional competence or conduct;

7.2.7.1.1.5. Voluntary surrender of membership or clinical privileges because of failure to submit a complete application for reappointment or renewal of privileges prior to the expiration of the current term of membership or clinical privileges.

7.2.7.1.1.6. Any other actions except those listed in Section 6.3 and 7.2.8.

7.2.8. ADVERSE RECOMMENDATIONS OR ACTIONS

Only individuals who are subject to an adverse recommendation or action are entitled to a hearing under these Bylaws if recommended by the Medical Executive Committee, or if taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where a right to hearing exists. The following recommendations or actions shall be deemed adverse and entitle the individual affected thereby to a hearing:

7.2.8.1. Denial of initial staff appointment;

7.2.8.2. Denial of reappointment;

7.2.8.3. Suspension of staff membership;

7.2.8.4. Revocation of staff membership;

7.2.8.5. Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations;

7.2.8.6. Denial of requested clinical privileges;

7.2.8.7. Involuntary reduction in clinical privileges;

7.2.8.8. Precautionary suspension or restriction of clinical privileges, as defined in Article Six, Section 6.3;

7.2.8.9. Revocation of clinical privileges; or,

7.2.8.10. Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to provisional status or the granting of new privileges).

7.2.9. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 7.3.1 shall promptly be given special written notice of such action. Such notice shall: 207

207 42 USCS §11112(b)(1)(A-C)
7.2.9.1. State the reasons for an adverse recommendation or action, with enough specifics to allow response;

7.2.9.2. Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.

7.2.9.3. Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing.

7.2.9.4. State that failure to request a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to an appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Trustees.

7.2.9.5. State a summary of the Practitioner’s rights at the hearing.

7.2.9.6. State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

7.2.10. REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 7.3.2 to file a written request for a hearing. Such requests shall be delivered to the Chief Executive Officer either in person or by certified mail.208

7.2.11. FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

7.2.11.1 An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall become effective pending the final approval of the Board.

7.2.11.2 An adverse action by the Board shall constitute acceptance of that action, which shall become immediately effective as the final decision by the Board.

7.3 HEARING PREREQUISITES

7.3.1 SPECIAL WRITTEN NOTICE

Upon receipt of a timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff or to the Trustees, depending on whose recommendation or action prompted the request for hearing. At least thirty (30) days prior to the hearing, the Practitioner shall be sent a special written notice stating the following:

7.3.1.1 The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise.209

7.3.1.2 A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;210

7.3.1.3 The Practitioner involved has the right:211

208 42 USC §11112(b)(1)(B)(i – ii)
209 42 USC §11112(b)(2)(A)
210 42 USC §11112(b)(2)(B)
7.3.1.3.1 To be present at the hearing;
7.3.1.3.2 To representation by an attorney or other person of the Practitioner’s choice;
7.3.1.3.3 To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;
7.3.1.3.4 To call, examine, and cross-examine witnesses;
7.3.1.3.5 To present evidence determined to be relevant by the Chairman of the hearing committee, regardless of its admissibility in a court law; and,
7.3.1.3.6 To submit a written statement at the close of the hearing.

7.3.1.4 Upon completion of the hearing, the Practitioner involved has the right:
7.3.1.4.1 To receive a record of the proceedings upon payment of a reasonable charge;¹²
7.3.1.4.2 To receive the written recommendation of the hearing committee, including a statement of the basis for the recommendations; and,
7.3.1.4.3 To receive a written decision of the Board of Trustees, including a statement of the basis for the decision.

7.3.1.5 The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

7.3.2. APPOINTMENT OF HEARING COMMITTEE

7.3.2.1. By Medical Staff: A hearing occasioned by an adverse recommendation of the Medical Executive Committee shall be conducted by an ad hoc hearing committee appointed by the President of the Medical Staff.

7.3.2.2. By Board: A hearing occasioned by an adverse action of the Board shall be conducted by a hearing committee appointed by the Chairman of Board.

7.3.2.3. Composition of Hearing Committee: The Hearing Committee shall be composed of at least three members. One of the members so appointed will be designated as the Chairman. No Member may serve who has acted as accuser, investigator, fact finder, or initial decision maker in the matter. Knowledge of the matter shall not preclude a Member from serving. No Member shall be appointed who is in direct economic competition with the Practitioner, or is a Member of the Medical Executive Committee or Board of Trustees. At least one Member shall be of the same medical specialty as the Practitioner. A majority of the members shall be members of the Medical Staff. However, if there are not a sufficient number of Medical Staff members willing or able to serve on the Hearing Committee, the Medical Executive Committee or the Board may appoint Practitioners who are not members of the Medical Staff.

---

¹² 42 USC §11112(b)(3)(i – v)
¹³ 42 USC §11112(b)(3)(D)(i – ii)
¹⁴ 42 USC §11112(b)(3)(C)(ii)
7.3.2.4. **Challenges for Cause:** The Practitioner may question hearing committee members regarding potential bias, prejudice or conflict of interest and challenge any Member of the hearing committee for any cause, which would indicate bias or predisposition. The Chairman, or if challenged, the President of the Medical Staff, shall decide the validity of such challenges. His/her decision shall be final.

7.4 **HEARING PROCEDURE**

7.4.1. **PERSONAL PRESENCE**

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 7.3.4.

7.4.2. **PRESIDING OFFICER**

The Chairman of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

7.4.3. **APPOINTMENT OF A HEARING OFFICER OR LEGAL CONSULTANT**

The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Chief of Staff or by the Chairman of the Board of Trustees if the adverse action was taken by the Board of Trustees. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act as the presiding officer of the hearing. Alternatively, the Chief of Staff may appoint an attorney to be a legal consultant to the Hearing Committee. The hearing officer or legal consultant may be present during deliberations, but shall not vote. Once a hearing officer has been appointed, he or she may only be removed for cause by the President of the Medical Staff with CEO approval.

7.4.4. **REPRESENTATION**

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice. 214 The Medical Executive Committee or the Board, depending on whose recommendation or action promoted the hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses.

7.4.5. **RIGHTS OF PARTIES**

During a hearing, each of the parties shall have the right to: 215

7.4.5.1. Call and examine witnesses;

7.4.5.2. Introduce exhibits;

7.4.5.3. Cross-examine any witness on any matter relevant to the issues;

7.4.5.4. Impeach any witness;

---

214 42 USCS §11112(b)(3)(C)(i)

215 42 USCS §11112(b)(3)(C)(iii – v)
7.4.5.5. Rebut any evidence; and

7.4.5.6. Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

7.4.6. PROCEDURE AND 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 shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing committee is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the Chairman’s discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

7.4.7. BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of their recommendation or action, but the Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the recommendation or action lacks any substantial factual basis or that the adverse recommendation or action is either arbitrary, unreasonable, or capricious.

7.4.8. RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit a valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A court reporter shall be present if requested by any party (at the expense of the requesting party).

7.4.9. POSTPONEMENT

Request for postponement of a hearing shall be granted by the Chairman to a date agreeable to the hearing committee only by stipulation between the parties or upon a showing of good cause.

7.4.10. PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

A majority of the hearing committee, but in no event less than three members, must be present throughout the hearing and deliberations. If a committee Member is absent from any part of the proceedings, that Member shall not be permitted to participate in the deliberations or to vote.

7.4.11. RECESSES AND ADJOURNMENT

The hearing committee may recess the hearing and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

7.5 HEARING COMMITTEE REPORT AND FURTHER ACTION

7.5.1 HEARING COMMITTEE REPORT
Within fourteen (14) days after the final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter, as decided by a majority of the entire hearing committee, and shall forward the same, together with the hearing record and all other documentation considered by it, to the Chief Executive Officer for distribution to the Medical Executive Committee and the Practitioner.

7.5.2. ACTION ON HEARING COMMITTEE REPORT

Within 30 days after receipt of the written report of the Hearing Committee, the Medical Executive Committee or Board, as the case may be, shall consider the report and affirm, modify or reverse its recommendations or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the Chief Executive Officer. The Medical Executive Committee or Board, as the case may be, may also request a status report by the Chairman of the hearing committee during the 30-day review period.

7.5.3. NOTICE AND EFFECT OF RESULT

7.5.3.1. Notice: The Chief Executive Officer shall promptly send a copy of the result and report to the Practitioner by special notice, to the Chief of Staff, to the Medical Executive Committee and to the Board.

7.5.3.2. Effect of Favorable Result:

7.5.3.2.1. Adopted by the Medical Executive Committee: If the Medical Executive Committee’s recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the Medical Executive Committee’s recommendation in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall within thirty (30) days take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

7.5.3.2.2. Adopted by the Board: If the Board’s initial hearing action is favorable to the Practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

7.5.3.3. Effect of Adverse Result for Practitioner: If the result of the Medical Executive Committee or of the Board continues to be adverse to the Practitioner in any of the respects listed in Section 7.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 7.7.1.

7.5.4. APPELLATE REVIEW
7.5.4.1. TIME FOR APPEAL

Within 10 days after receipt of notice of the Medical Executive Committee’s or Board of Trustees’ decision, under Section 6.6.2 of these Bylaws, upon the Hearing Panel’s recommendation either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within the 10 day period, an appeal is deemed to be waived and the Hearing Panel’s report and recommendation shall be forwarded to the Board of Trustees for final action.

7.5.4.2. GROUNDS FOR APPEAL

The grounds for appeal shall be limited to the following:

7.5.4.2.1. There was substantial failure to comply with the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

7.5.4.2.2. The recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.5.4.3. TIME, PLACE AND NOTICE

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board of Trustees shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.5.4.4. NATURE OF APPELLATE REVIEW

7.5.4.4.1. The Board of Trustees may consider the appeal as a whole body, or the Chairperson of the Board of Trustees may appoint a Review Panel composed of three (3) persons, either members of the Board of Trustees or others, including, but not limited to, reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board of Trustees.

7.5.4.4.2. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten (10) days to respond. In its sole discretion, the Board of Trustees (or Review Panel) may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.

7.5.4.4.3. The Board of Trustees (or Review Panel) may, in its sole discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing
Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence, or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Board of Trustees (or Review Panel).

7.5.5. APPELLATE REVIEW IN THE EVENT OF BOARD OF TRUSTEES MODIFICATION OR REVERSAL OF HEARING PANEL RECOMMENDATION

If the Board of Trustees determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review, and such action would adversely affect the individual, the Board of Trustees shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal. The Board of Trustees shall take no final action until the individual has exercised or has waived that appeal provided in these Bylaws. The Board of Trustees has the final say in the matter.

7.5.6. FINAL DECISION OF THE BOARD OF TRUSTEES

7.5.6.1. Within thirty (30) days after the Board of Trustees (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel’s report and recommendation when no appeal has been requested, the Board of Trustees shall consider the matter and take final action.

7.5.6.2. The Board of Trustees may review any information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel. The Board of Trustees may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board of Trustees’ ultimate legal authority for the operation of the Hospital and the quality of care provided.

7.5.6.3. The Board of Trustees shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

7.5.7. FURTHER REVIEW

Except where the matter is referred by the Board of Trustees for further action and recommendation by any individual or committee, the final decision of the Board of Trustees shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board of Trustees in accordance with the instructions given by the Board of Trustees.

7.5.8. GENERAL PROVISIONS

BOARD OF TRUSTEES ACTION
The procedures specified herein shall not preclude the Board of Trustees from taking any direct action authorized under the Board of Trustees Bylaws, policies and/or procedures.  

7.5.9. NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to a specific adverse recommendation or action.

7.5.10. RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions of Article Twelve in these Bylaws relating to immunity from liability in all matters relating thereto.

7.5.11. CONFIDENTIALITY

The investigations, proceedings and records conducted or created for the purpose of carrying out the provisions of the Fair Hearing Plan or for conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential, protected by State and Federal Law.

7.5.12. HEARING AND APPEAL PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS

Individuals with clinical privileges who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e., Advanced Practice Professionals - APPs) are afforded a fair hearing and appeal process but that process shall be a modification of that for Medical Staff members or applicants for Medical Staff membership. The following procedures shall be used for Advanced Practice Professionals:

7.5.12.1. Notice: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the Advanced Practice Professionals subject to the adverse recommendation or action. The notice shall state that the Advanced Practice Professionals has thirty (30) days in which to request a hearing. If the Advanced Practice Professionals does not request a hearing within thirty (30) days, the Advanced Practice Professionals shall have waived right to a hearing.

7.5.12.2. Hearing Panel: The Chief Executive Officer shall appoint a hearing panel, which will include three (3) members. The panel members shall include the Chief Executive Officer, the President of the Medical Staff or another officer of the Medical Staff, and a peer of the Advanced Practice Professionals. None of the panel members shall have had a role in the adverse recommendation or action.

7.5.12.3. Rights: The Advanced Practice Professionals subject to the adverse recommendation or action shall have the right to

---


217 MS.10.01.01
7.5.12.4. Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination:

7.5.12.4.1. A determination favorable to the Advanced Practice Professionals shall be reported in writing to the body making the adverse recommendation or action.

7.5.12.4.2. A determination adverse to the Advanced Practice Professionals shall result in notice to the Advanced Practice Professionals of the right to appeal the decision to the Chairman of the Board.

7.5.12.4.3. Final Decision: The decision of the Chairman of the Board shall be final.

7.5.13. EXTERNAL REPORTING REQUIREMENTS

The Hospital shall submit a report to the appropriate state professional licensure board (i.e., the state agency that issued the individual’s license to practice) and all other agencies as required by all applicable Federal and/or State law(s) and in accordance with Hospital policy and procedures.218

ARTICLE EIGHT: MEDICAL STAFF OFFICERS

8.1. ELECTED OFFICERS OF THE STAFF

8.1.1. IDENTIFICATION

The officers of the Medical Staff shall be the President of the Medical Staff, the President of the Medical Staff-Elect, the Secretary-Treasurer, and the Immediate Past President of the Medical Staff.

8.1.2. QUALIFICATIONS

Officers must be members of the active staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office.219 Failure to maintain such status or loss of license or Hospital privileges shall immediately create a vacancy in the office involved.220, 221 To qualify for the position of President of the Medical Staff or President of the Medical Staff-Elect, a Member of the Medical Staff must be a doctor of medicine or osteopathy.222 Except for these specific qualification requirements, no Medical Staff Member actively practicing in the Hospital is ineligible for election to an officer position solely because of his/her professional discipline, specialty, or practice as a hospital-based physician.

218 42 USCS §11133(a)
219 MS.01.01.01
220 MS.01.01.01
222 LD.01.05.01, §482.22(b)(3)
8.1.3. Only those members of the Active Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must continuously meet the following qualifications to be a nominee and to serve as an officer of the Medical Staff:

8.1.3.1. To have membership in good standing on the Active Medical Staff, and to have served on the Active Medical Staff for at least five years;

8.1.3.2. To not be under investigation by the Medical Staff or any local, state or Federal agency with regard to professional practice, and to have no adverse recommendations concerning Medical Staff appointment or clinical privileges;

8.1.3.3. To have experience in a leadership position for at least two years, or other involvement in performance improvement functions;

8.1.3.4. To attend continuing education relating to Medical Staff leadership and/or credentialing functions during the term of the office.

8.2. TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

8.2.1. TERM OF OFFICE

Each officer shall serve a two (2) year term. The term of office shall commence on the first day of the medical staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is otherwise unable to complete the term. At the end of the President of the Medical Staff’s term, the President of the Medical Staff-Elect shall automatically assume that office and the President of the Medical Staff shall automatically serve as the Immediate Past President of the Medical Staff.223

8.2.2. ELIGIBILITY FOR RE-ELECTION

No person may serve in the same position for more than two consecutive terms.

8.3. ATTAINMENT OF OFFICE

8.3.1. NOMINATION

At least sixty (60) days before the General Staff meeting held in last half of each election year, the Nominating Committee shall convene and submit to the President of the Medical Staff one or more qualified nominees for the offices of President of the Medical Staff-Elect and Secretary-Treasurer. The Nominating Committee shall report the names of the nominees to the Staff at least sixty (60) days before the annual meeting held in Autumn. Nominations may also be made by petition signed by at least ten percent of the appointees of the active staff, with a signed statement of willingness to serve by the nominee, filed with the President of the Medical Staff at least forty-five (45) days before the annual meeting. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Nominating Committee shall submit one or more additional nominees at the annual meeting and nominations may be accepted from the floor if the nominee is present at the meeting and consents to the nomination.

8.3.2. ELECTION

223 MS.01.01.01
Officers may be elected by electronic voting using a secure system or by paper ballots approved by the Medical Executive Committee. Only members of the Active Medical Staff shall be eligible to vote. The ballot shall be sent out electronically to all Active Staff members to each member’s email address of record at least thirty (30) days prior to the end of the Medical Staff year. Active Staff members shall have one week (seven calendar days) to submit their votes. Voting may also be done at the election meeting by secret written ballot, and authenticated sealed mailed ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held at the meeting by secret written ballot. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.224

8.3.3. BOARD APPROVAL/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department and Division officers, who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment/performance improvement activities.225 The Board’s ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assessment/performance improvement activities. Such activities shall have the following characteristics:226

8.3.3.1. The activities such leaders undertake shall be performed on behalf of the Hospital;

8.3.3.2. The activities shall be performed in good faith;

8.3.3.3. That any professional review action shall be taken:

8.3.3.3.1. In the reasonable belief that the action was in the furtherance of quality health care;

8.3.3.3.2 After a reasonable effort to obtain the facts of the matter;

8.3.3.3.3 After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,

8.3.3.3.4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.

---

224 MS.01.01.01
225 42 USCS §11111
226 42 USCS §11112(a)(1-4)
8.3.3.4. The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;

8.3.3.4.1. Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

8.4. VACANCIES

8.4.1. WHEN CREATED

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer’s failure to maintain active staff status in good standing.

8.4.2. OFFICE OF THE PRESIDENT OF THE MEDICAL STAFF

When a vacancy occurs in the office of the President of the Medical Staff, then the President of the Medical Staff-Elect shall serve the remaining term of the former President of the Medical Staff. The vacancy then created in the office of President of the Medical Staff-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the President of the Medical Staff and President of the Medical Staff-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the Board shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

8.4.3. MEDICAL STAFF OFFICERS OTHER THAN THE PRESIDENT OF THE MEDICAL STAFF

When a vacancy occurs in the office of the President of the Medical Staff-Elect, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election, when both a President of the Medical Staff and President of the Medical Staff-Elect shall be elected. When a vacancy occurs in the office of the Secretary-Treasurer, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election. When a vacancy occurs in the office of the Immediate Past President of the Medical Staff, the office shall remain vacant until after the next election.

8.5. RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

8.5.1. RESIGNATION

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

8.5.2. REMOVAL

Any Medical Staff officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal from office for cause, with approval by the Board, or with the majority vote of the Board. Grounds for
removal may include any one or more of the following causes, without limitations:

8.5.2.1. Failure to perform the duties of office;

8.5.2.2. Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

8.5.2.3. Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

8.5.2.4. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,

8.5.2.5. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

8.5.3. RECALL FROM OFFICE

Any Medical Staff officer may be recalled from office, with or without cause. Recall of a Medical Staff officer may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the medical staff members eligible to vote in Medical Staff elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. A recall shall require two-thirds of the votes of the Medical Staff members attending the specially called meeting who are eligible to vote. Sealed and authenticated votes mailed by Medical Staff members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

8.6. RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS

8.6.1. PRESIDENT OF THE MEDICAL STAFF

The President of the Medical Staff shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for the organization and conduct of the Medical Staff, and supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the President of the Medical Staff are to:

8.6.1.1. Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;

8.6.1.2. Serve as chairperson of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

8.6.1.3. Serve as ex-officio Member of all other Medical Staff committees without vote, unless otherwise specified;

8.6.1.4. Appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad

---

227 MS.01.01.01
228 MS.01.01.01
229 LD.01.05.01; 42 C.F.R. §482.22(b)(3)
committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Board;

8.6.1.5. Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies, implement sanctions when indicated, and enforce the Medical Staff’s compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;

8.6.1.6. Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;

8.6.1.7. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Chief Executive Officer and the Board, and serve as an ex-officio Member of the Board, with a vote;

8.6.1.8. Receive and interpret the opinions, policies, and directives of the Administration and the Board to the Medical Staff;

8.6.1.9. Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,

8.6.1.10. Perform all other functions as may be assigned to the President of the Medical Staff by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Board.

8.6.2. PRESIDENT OF THE MEDICAL STAFF-ELECT

The President of the Medical Staff-Elect shall perform the duties of the President of the Medical Staff in the absence or temporary inability of the President of the Medical Staff to perform. The President of the Medical Staff-Elect shall serve as the vice-chairperson of the Medical Executive Committee and shall perform such additional duties as may be assigned by the President of the Medical Staff or the Board.

8.6.3. SECRETARY-TREASURER

The Secretary-Treasurer shall be a Member of the Medical Executive Committee. The duties of the Secretary-Treasurer are to:

8.6.3.1. Maintain a roster of Medical Staff members;

8.6.3.2. Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings with the assistance of Medical Staff Office personnel;

8.6.3.3. Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the President of the Medical Staff;

8.6.3.4. Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff with the assistance of Medical Staff Officer personnel; and,

8.6.3.5. Maintain a record of Medical Staff dues, collections, and accounts, if applicable, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority.

8.6.4. IMMEDIATE PAST PRESIDENT OF THE MEDICAL STAFF
As an individual with unique knowledge of Medical Staff affairs, the Immediate Past President of the Medical Staff shall serve as an advisor and mentor to the President of the Medical Staff, shall participate as a Member of the Medical Executive Committee and other standing committees of the Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the President of the Medical Staff.

8.7. CHIEF MEDICAL OFFICER
The Chief Medical Officer shall be a physician who is employed or under contract with the Hospital to perform administrative duties related to the medical staff affairs of the Hospital. The Chief Medical Officer is not elected by the Medical Staff and therefore is not one of the officers of the Medical Staff organization. The Chief Medical Officer is a Medico-Administrative Officer, and as such, the provisions of Article Three, Section 3.14 of these Bylaws apply.

8.7.1. QUALIFICATIONS
The Chief Medical Officer shall possess all of the qualifications for Medical Staff membership if the Chief Medical Officer desires Medical Staff membership or clinical privileges to provide patient care services.

8.7.2. RESPONSIBILITIES AND AUTHORITY
The Chief Medical Officer shall serve as an advisor to the officers of the Medical Staff and as a liaison between the Medical Staff and the Administration of the Hospital. The authority of the Chief Medical Officer shall be that of an administrator of the Hospital, as assigned by the Chief Executive Officer. Specific responsibilities include, but are not limited to:

8.7.2.1. Administratively oversee the Medical Staff Office in performance of the credentialing function;

8.7.2.2. Serve as a designee of the Chief Executive Officer in reviewing and approving applications for temporary privileges;

8.7.2.3. Serve as an ex-officio Member of all Medical Staff committees, without vote;

8.7.2.4. Advise and assist the officers of the Medical Staff in the performance of their duties, including providing orientation and education to Medical Staff leaders with regard to their leadership roles.

8.7.3. APPOINTMENT
After having received input from the Medical Executive Committee, Chief Medical Officer shall be appointed by the Chief Executive Officer and approved by the Board.

8.7.4. VACANCY
In the event of a vacancy in the position of Chief Medical Officer, the President of the Medical Staff shall ensure that any Medical Staff functions associated with the position are performed.

9. ARTICLE NINE: CLINICAL DEPARTMENTS AND SPECIALTY DIVISIONS
9.1. DESIGNATION
9.1.1. CURRENT CLINICAL DEPARTMENTS
The Medical Staff shall be organized into clinical Departments. The Medical Staff Departments are:\textsuperscript{230}

9.1.1.1. Medicine Department
9.1.1.2. Surgery Department
9.1.1.3. Maternal/Child Department
9.1.1.4. Anesthesia Department
9.1.1.5. Emergency Medicine Department
9.1.1.6. Radiology Department
9.1.1.7. Pathology Department

9.1.2. SPECIALTY DIVISIONS WITHIN A DEPARTMENT

Each Department may be further subdivided into specialty Divisions. The Divisions are:\textsuperscript{231}

9.1.2.1. For the Medicine Department:
   9.1.2.1.1. Allergy/Immunology
   9.1.2.1.2. Cardiovascular Disease
   9.1.2.1.3. Critical Care Medicine
   9.1.2.1.4. Dermatology
   9.1.2.1.5. Endocrinology
   9.1.2.1.6. Family Medicine
   9.1.2.1.7. Gastroenterology
   9.1.2.1.8. Hematology/Oncology
   9.1.2.1.9. Hospitalist
   9.1.2.1.10. Internal Medicine
   9.1.2.1.11. Nephrology
   9.1.2.1.12. Neurology
   9.1.2.1.13. Physical Medicine/Rehabilitation
   9.1.2.1.14. Psychiatry
   9.1.2.1.15. Rheumatology

9.1.3. For the Surgery Department:
   9.1.3.1. Cardiothoracic Surgery
   9.1.3.2. Otolaryngology
   9.1.3.3. General Surgery
   9.1.3.4. Neurosurgery
   9.1.3.5. Ophthalmology

\textsuperscript{230} MS.01.01.01, MS.06.01.07, LD.04.01.05
\textsuperscript{231} MS.01.01.01, MS.06.01.07, LD.04.01.05
| 9.1.3.6. | Orthopedics          |
| 9.1.3.7. | Podiatry             |
| 9.1.3.8. | Plastic Surgery      |
| 9.1.3.9. | Urology              |
| 9.1.3.10.| Vascular Surgery     |

9.1.4. For the Maternal/Child Department:
- 9.1.4.1. Neonatology
- 9.1.4.2. Obstetrics/Gynecology
- 9.1.4.3. Pediatrics

9.2. CRITERIA TO QUALIFY AS A DEPARTMENT OR DIVISION
The Medical Executive Committee may create, eliminate, subdivide or combine Departments or Divisions, subject to approval by the Board, based on the evolving scope of clinical services of the Hospital and the need of the Medical Staff organization to most effectively support the oversight of quality of patient care. Since the primary function of a Department or a Division is to be responsible for the quality of patient care provided by the members of the Department or Division, the primary criteria for creating or subdividing a Department or Division, or in eliminating or combining a Department or Division shall be whether the Department or Division has a sufficient number of active staff members and sufficient patient volume to support the quality assessment and performance improvement activities required of a Department or Division.

9.3. REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS AND DIVISIONS
Each Medical Staff Member and other individuals with clinical privileges shall be assigned to one Department by the Board based on recommendations from the Medical Executive Committee. A Medical Staff Member or other individual with clinical privileges may be assigned to a Division if one exists related to the Member’s or individual’s clinical specialty. A Member or other individual with clinical privileges may be granted clinical privileges in one or more other Departments. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of the Department and the authority of the Department Chairperson.

9.4. FUNCTIONS OF DEPARTMENTS
The Departments shall meet at least twice a year to perform the following functions:

9.4.1. CLINICAL FUNCTIONS

- 9.4.1.1. Serve as a forum for the exchange of clinical information regarding services provided by Department members;
- 9.4.1.2. Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department members;
- 9.4.1.3. Provide recommendations to the Department Chairperson regarding professional criteria for clinical privileges designed to assure the Medical...
Staff and Board that patients shall receive quality care. The recommendations shall include:

9.4.1.4. Criteria for granting, withdrawing and modifying clinical privileges;

9.4.1.5. A procedure for applying these criteria to individuals requesting privileges.

9.4.1.6. Ensure that patients receive appropriate and medically necessary care from a Member of the Medical Staff during the entire length of stay with the Hospital;

9.4.1.7. Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges;

9.4.1.8. By establishing uniform patient care processes;

9.4.1.8.1. By establishing similar clinical privileging criteria for similar privileges;

9.4.1.8.2. By using similar indicators in performance improvement activities.

9.4.1.9. Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;

9.4.1.10. Ensure effective mechanisms for the clinical supervision of Advanced Practice Professionals, and House Staff practitioners, if any.

9.4.1.11. Coordinate the patient care provided by the department’s appointees with nursing and other non-physician patient care services and with administrative support services.

9.4.2. ADMINISTRATIVE FUNCTIONS

9.4.2.1. Provide information and/or recommendations to the Department Chairperson with regard to the criteria for granting clinical privileges within the Department;

---

232 MS.02.01.01, MS.06.01.07
233 42 C.F.R. §482.22(c)(6), CMS Survey Procedures
234 42 C.F.R. §482.22(c)(6), CMS Survey Procedures
235 MS.03.01.01
236 LD.04.03.07
237 MS.01.01.01; LD.01.05.01
238 MS.01.01.01; LD.01.05.01
9.4.2.2. Ensure that individuals within the Department who admit patients have privileges to do so, and that all individuals within the Department with clinical privileges only provide services within the scope of privileges granted.

9.4.2.3. Provide information and/or recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to Medical Staff policies and procedures;

9.4.2.4. Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Department members.

9.4.3. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY ACTIVITIES

9.4.3.1. Perform peer review and quality assessment activities relative to the performance of individuals with clinical privileges in the Department and report such activities to the Medical Executive Committee on a regular basis;

9.4.3.2. Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals.

9.4.3.3. Ensure appropriate quality control is performed, if applicable to the Department;

9.4.3.4. Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department’s performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

9.4.4.5. COLLEGIATE AND EDUCATIONAL FUNCTIONS

Recommend medical educational programs to meet the needs of Department members, based on the scope of services provided by the Department, changes in medical practice or technology, and the results of Departmental performance improvement activities.

9.4.5. FUNCTIONS OF DIVISIONS

The Divisions shall meet as often as necessary at the call of the Division Director to perform the following functions:

9.4.5.1. The Division meetings shall serve as a forum to discuss clinical aspects of care related to the Division;

---

239 MS.03.01.01, MS.06.01.07
240 MS.08.01.03
241 MS.03.01.01; 42 C.F.R. §482.22
242 MS.12.01.01
9.4.5.2. The Division may be requested by the Department Chairperson or Medical Executive Committee to meet to discuss specific issues related to quality assessment, peer review, performance improvement, and/or credentialing. In such cases, the Division shall report their findings directly to the Department Chairperson or the Medical Executive Committee.

9.4.6. OFFICERS OF DEPARTMENTS AND DIVISIONS

9.4.6.1. IDENTIFICATION

The officers of the Departments and Divisions shall be the Department Chairperson, the Department Chair-elect, and the Division Director.

9.4.7. QUALIFICATIONS

The officers of the Departments and Divisions shall be active staff members in good standing. Each Department Chairperson and Chair-elect shall have demonstrated ability in at least one of the clinical areas of the Department. The Division Director shall have demonstrated ability in the specialty represented by the Division. All officers of the Departments and Divisions shall be certified by an appropriate specialty board, or affirmatively establishes comparable competence through the credentialing process.\(^{243}\)

9.4.8. ATTAINMENT OF OFFICE

Department officers shall be elected by a majority vote of the Department members eligible to vote and in attendance at the last meeting of the Department every other year. The officers selected during the election shall be subject to ratification by the Board and shall take office at the beginning of the subsequent medical staff year. The Chairperson of the Department to which the Division is affiliated shall appoint the Division Director.\(^{244}\)

9.4.9. TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

Department and Division officers shall serve a term of office of two years with term limits established by the Department and Division.\(^{245}\)

9.4.10. RESIGNATION

Any Department or Division officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

9.4.11. REMOVAL

Any Department or Division officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether sufficient evidence exists for grounds for removal, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:\(^ {246}\)

9.4.11.1. Failure to perform the duties of office;

\(^{243}\) MS.01.01.01, MS.06.01.07, LD.04.01.05
\(^{244}\) MS.01.01.01
\(^{245}\) MS.01.01.01
\(^{246}\) MS.01.01.01
9.4.11.2. Failure to comply with or support the enforcement of the Hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

9.4.11.3. Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

9.4.11.4. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing and/or failure to maintain specialty board certification or comparable competence; and/or,

9.4.11.5. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

9.4.12. RECALL

Any Department officer may be recalled from office, with or without cause. Recall of a Department officer may be initiated by a petition signed by at least one-third of the Department members eligible to vote in medical Staff-Elections. Recall shall be considered by the members of the Department at a special meeting of the Department called for that purpose. A recall shall require two-thirds of the votes of the Department members attending the specially called meeting who are eligible to vote. Sealed, authenticated votes mailed by Department members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

9.4.13. VACANCY

In the event of a vacancy in one of the Department officer positions, the President of the Medical Staff shall appoint an interim officer from the Active membership of the Department until an election can be held at the next Department meeting. In the event of a vacancy in a Division Director position, the Chairperson of the Department to which the Division is affiliated shall appoint a new Division Director.

9.4.14. RESPONSIBILITY AND AUTHORITY\textsuperscript{247}

9.4.14.1. \textbf{Department Chairperson:}\ Each Department Chairperson shall be responsible for the organization of the Department and delegation of duties to Department members to promote quality of patient care in the Department. Members of the Department and others with clinical privileges in the Department shall be responsible to the Department Chairperson. Each Department Chairperson shall be responsible for the following duties:

9.4.14.1.1. Presiding at all meetings of the Department;

9.4.14.1.2. Appointing Department members to the positions of Division Director and to membership positions on Departmental committees, if any;

9.4.14.1.3. Serving as an ex-officio Member of all departmental committees if any, without

\textsuperscript{247} MS.01.01.01, MS.06.01.07, LD.04.01.05
vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;

9.4.14.4. Serving as a Member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly report the quality assessment and performance improvement activities of the Department to the Medical Executive Committee;

9.4.14.5. Conducting all clinically related activities of the Department;\textsuperscript{248}

9.4.14.6. Conducting all administratively related activities of the Department, unless otherwise provided by the Hospital;\textsuperscript{249}

9.4.14.7. Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;\textsuperscript{250}

9.4.14.8. Participating in the evaluation of Practitioners practicing within the department;\textsuperscript{251}

9.4.14.9. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;\textsuperscript{252}

9.4.14.10. Recommending clinical privileges for each Member of the Department;\textsuperscript{253}

9.4.14.11. Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;\textsuperscript{254}

9.4.14.12. Integrating the Department into the primary functions of the Hospital;\textsuperscript{255}

9.4.14.13. Coordinating and integrating interdepartmental and intradepartmental services;\textsuperscript{256}

\textsuperscript{248} MS.01.01.01, MS.06.01.07, LD.04.01.05
\textsuperscript{249} MS.01.01.01, MS.06.01.07, LD.04.01.05
\textsuperscript{250} MS.01.01.01, MS.06.01.07, LD.04.01.05
\textsuperscript{251} MS.01.01.01, MS.06.01.07, LD.04.01.05
\textsuperscript{252} MS.01.01.01, MS.02.01.01, MS.06.01.07, LD.04.01.05, 42 C.F.R. §482.22(c)(6)
\textsuperscript{253} MS.01.01.01, MS.06.01.07, LD.04.01.05
\textsuperscript{254} MS.01.01.01, LD.04.03.01, LD.04.03.09
\textsuperscript{255} MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
\textsuperscript{256} MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
9.4.14.1.14. Developing and implementing policies and procedures that guide and support the provision of services;

9.4.14.1.15. Recommending a sufficient number of qualified and competent persons to provide care or services;

9.4.14.1.16. Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;

9.4.14.1.17. Ensuring the continuous assessment and improvement of the quality of care and services provided;

9.4.14.1.18. Maintaining quality control programs, as appropriate;

9.4.14.1.19. Ensuring the orientation and continuing education of all persons in the Department;

9.4.14.1.20. Recommending appropriate space and other resources needed by the Department.

9.4.14.2. Department Chair-Elect: The Department Chair-Elect shall assist the Department Chairperson in the performance of the Chairperson’s duties, and shall assume the duties of the Chairperson in his/her absence.

9.4.14.3. Division Director: The Division Director shall be responsible for promoting quality of patient care in the Division. Each Division Director shall be responsible for the following duties:

9.4.14.3.1. Calling and giving notice of a meeting of the Division members, to be held on an ad hoc basis, when issues are identified that require the members to deliberate quality of care issues unique to their specialty. The Division Director shall preside at all of the meetings of the Division;

9.4.14.3.2. Being accountable to the Department Chairperson with regard to the activities and functioning of the Division, specifically to report any quality assessment and performance improvement activities of the Division at the meetings of the Department.

---

257 MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
258 MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
259 MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
260 MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
261 MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
262 MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
263 MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01
10. **ARTICLE TEN: FUNCTIONS AND COMMITTEES**

10.1. **FUNCTIONS OF THE STAFF**

Individual members of the Medical Staff and others with clinical privileges care for patients within an organization context. Within this context, members of the Medical Staff and those individuals with clinical privileges, as individuals and as a group, interface with, and actively participate in important organization functions. Key functions of the Medical Staff are outlined below, and are performed through the Departments, Divisions, and committees that compose the Medical Staff structure.

10.2. **GOVERNANCE**

Although the Medical Staff is an integral part of the Hospital and is not a separate legal entity, the Medical Staff is organized to perform its required functions. The Medical Staff organization shall:

10.2.1. Establish a framework for self-governance of Medical Staff activities and accountability to the Board.\(^{264}\)

10.2.2. Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.\(^{265}\)

10.3. **PLANNING**

The leaders of the Hospital include members of the Board, the Chief Executive Officer and other senior managers, Department leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Departments and other Medical Staff members in medico-administrative positions, and the Chief Nursing Officer and other senior nursing leaders.\(^{266}\) Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

10.3.1. Planning patient care services;\(^{267}\)

10.3.2. Planning and prioritizing performance improvement activities;\(^{268}\)

10.3.3. Budgeting;\(^{269}\)

10.3.4. Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and

---

\(^{264}\) MS.01.01.01, MS.01.01.03

\(^{265}\) MS.03.01.03, LD.1.10, LD.03.04.01

\(^{266}\) Joint Commission Comprehensive Accreditation Manual for Hospitals, Glossary

\(^{267}\) LD.02.01.01

\(^{268}\) LD.03.03.01; LD.03.05.01; LD.04.04.01; PI.03.01.01

\(^{269}\) LD.04.01.03
non-members of the Medical Staff who have delineated clinical privileges;\textsuperscript{270}

10.3.5. Recruitment, retention, development, and continuing education of all staff;\textsuperscript{271}

10.3.5.1. Consideration and implementation of clinical practice guidelines as appropriate to the patient population;\textsuperscript{272}

10.3.5.2. Establishing and maintaining responsibility for written policy and procedures governing medical care provided in the hospital, the emergency service department and all affiliated outpatient settings;\textsuperscript{273}

10.3.5.3. When emergency services are provided at the Hospital but not at one or more off-campus locations of the Hospital, the Medical Staff shall have policy and procedures for appraisal of emergencies, initial treatment when needed, and acceptance of patients from the off-campus locations;\textsuperscript{274}

10.3.5.4. If emergency services are not provided at the Hospital, the Medical Staff shall have written policy and procedures for appraisal of emergencies, initial treatment, and referral of patients when needed;\textsuperscript{275}

10.3.5.5. The Medical Staff shall attempt to secure autopsies in all cases of unusual deaths and of medical legal and educational interest;\textsuperscript{276}

10.3.5.6. The Medical Staff, specifically the attending physician, shall be informed of autopsies that the Hospital intends to perform.\textsuperscript{277}

10.4. CREDENTIALING AND PRIVILEGING

The Medical Staff is fully responsible to the Board for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of clinical privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

10.4.1. Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership, and for granting delineated clinical privileges to qualified applicants.\textsuperscript{278}

10.4.2. Establish professional criteria for membership and for clinical privileges.\textsuperscript{279}

10.4.3. Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges.\textsuperscript{280}

10.4.4. Submit recommendations to the Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges.\textsuperscript{281}

\textsuperscript{270} LD.02.01.01; MS.01.01.01; LD.01.05.01
\textsuperscript{271} LD.02.01.01, LD.03.06.01
\textsuperscript{272} LD.04.04.07
\textsuperscript{273} MS.03.01.01
\textsuperscript{274} MS.03.01.01
\textsuperscript{275} MS.03.01.01
\textsuperscript{276} MS.05.01.01
\textsuperscript{277} MS.05.01.01
\textsuperscript{278} MS.01.01.01
\textsuperscript{279} MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03
\textsuperscript{280} MS.06.01.07
\textsuperscript{281} MS.01.01.01, MS.06.01.03, MS.06.01.07
10.4.5. Establish a mechanism for fair hearing and appellate review.\textsuperscript{282}

10.4.6. Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.\textsuperscript{283}

10.5. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Board requires that the Medical Staff is accountable to the Board for the quality of care provided to patients.\textsuperscript{284} All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital’s quality assessment and performance improvement activities.\textsuperscript{285} All organized services related to patient care shall be evaluated.\textsuperscript{286} The Hospital’s quality assessment and performance improvement activities shall be described in detail in the Performance Improvement Plan. Through the activities of the Medical Staff Departments and Divisions, the Medical Staff Quality/Peer Review Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below.\textsuperscript{287} The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members and the Board of Trustees.\textsuperscript{288}

10.5.1. Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program. The Board, the Medical Staff, and Administration shall be responsible and accountable for ensuring the following:\textsuperscript{289}

10.5.1.1. That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

10.5.1.2. That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.

10.5.1.3. That clear expectations for safety are established.

10.5.1.4. That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital’s performance and reducing risk to patients.

10.5.1.5. That the determination of the number of distinct improvement projects is conducted annually.

10.5.2. Medical Staff Leadership Role in Performance Improvement:

\textsuperscript{282} MS.10.01.01
\textsuperscript{283} MS.08.01.03
\textsuperscript{284} 42 C.F.R. §482.12(a)(5)
\textsuperscript{285} MS.01.01.01, MS.05.01.01, MS.06.01.07, MS.08.01.03; 42 C.F.R. §482.22(a)(1)
\textsuperscript{286} 42 C.F.R. §482.21(a)(1)
\textsuperscript{287} 42 C.F.R §482.22(a)(1), 42 C.F.R. §482.22(c)(3), Survey Procedures
\textsuperscript{288} MS.05.01.03
\textsuperscript{289} 42 C.F.R. §482.21 (effective March 25, 2003)
10.5.2.1. The Medical Staff shall perform a leadership role in the Hospital’s quality assessment, performance improvement, and patient when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges. Such activities shall include, but are not limited to a review of the following:

10.5.2.1.1. Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;

10.5.2.1.2. Root cause analysis, investigation and response to any unanticipated adverse events;

10.5.2.1.3. Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;

10.5.2.1.4. Review and analysis of performance based on the results of core measures and other publicly reported performance information;

10.5.2.1.5. Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;

10.5.2.1.6. Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;

10.5.2.1.7. Use of blood and blood components, including the review of any significant transfusions reactions;

10.5.2.1.8. Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses.

---

290 MS.05.01.01
291 LD.04.04.05, MS.05.01.01
292 LD.04.04.05, MS.05.01.01
293 MS.05.01.01; 42 C.F.R. §482.21(a)(3)
294 Hospital Quality Alliance and public reporting initiatives
295 MS.05.01.01
296 MS.05.01.01; 42 C.F.R. §482.21; 42 C.F.R. §482.23(c)(4); 42 C.F.R. §482.25(b)(6)
297 MS.05.01.01; MS.05.01.01; 42 C.F.R. §482.21
298 MS.05.01.01; MS.05.01.01; 42 C.F.R. §482.21
10.5.2.1.9. Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review; 299

10.5.2.1.10. Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff; and, 300

10.5.2.1.11. Use of developed criteria for autopsies. 301

10.5.3. **Medical Staff Participant Role in Performance Improvement:**

The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes. 302 Such activities shall include, but are not limited to a review of the following:

10.5.3.1. Analyzing and improving patient satisfaction; 303

10.5.3.2. Education of patients and families; 304

10.5.3.3. Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and, 305

10.5.3.4. Accurate, timely, and legible completion of patients’ medical records, including a review of medical record delinquency rates; 306

10.5.3.5. The quality of history and physical exams; 307

10.5.3.6. Surveillance of nosocomial infections. 308

10.5.4. **Medical Staff OPPE, FPPE & Peer Review:** Findings relevant to an individual are used in an ongoing evaluation to verify continued competence for the privileges granted, and focused professional practice evaluation (FPPE) for both the initial appraisal of the individual’s competence and when indicated for-cause. 309 When the findings of quality assessment or performance improvement activities are relevant to an individual’s performance and the individual is a Medical Staff Member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in FPPE, OPPE or peer review. In accordance with these Bylaws, clinical privileges are

---

299 MS.05.01.01; 42 C.F.R. §482.21; 42 C.F.R. §482.30
300 MS.05.01.01; 42 C.F.R. §482.21
301 MS.05.01.01
302 MS.05.01.03
303 MS.03.01.01
304 MS.05.01.03
305 MS.05.01.03
306 MS.05.01.03; RC.01.03.01; 42 C.F.R. §482.21
307 MS.03.01.01
308 IC.01.03.01; 42 C.F.R. §482.21(a)(2); 42 C.F.R. §482.42(b)(1 – 2)
309 MS.05.01.03
renewed or revised appropriately as determined by the Medical Staff or Board based on OPPE or FPPE findings.\textsuperscript{310}

\textbf{10.6. CONTINUING AND GRADUATE MEDICAL EDUCATION}

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education.\textsuperscript{311} In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital’s mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Hospital policy.\textsuperscript{312} The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

10.6.1. The type and nature of care offered by the hospital; and,\textsuperscript{313}

10.6.2. The findings of performance improvement activities.\textsuperscript{314}

Additionally, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of house staff members in carrying out their patient care responsibilities.\textsuperscript{315}

\textbf{10.7. BYLAWS REVIEW AND REVISION}

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

10.7.1. Remain consistent with the Bylaws of the Board of Trustees;\textsuperscript{316}

10.7.2. Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;\textsuperscript{317}

10.7.3. Remain current with the Medical Staff’s organization, structure, functions, responsibilities and accountabilities;\textsuperscript{318} and,

10.7.4. Remain consistent with Hospital policies.\textsuperscript{319}

\textbf{10.8. NOMINATING}

The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization.\textsuperscript{320}

\textbf{10.9. PRINCIPLES GOVERNING COMMITTEES}

\begin{itemize}
\item \textsuperscript{310} MS.05.01.03; 42 C.F.R. §482.22(a)(1)
\item \textsuperscript{311} MS.12.01.01
\item \textsuperscript{312} MS.12.01.01, HCA, Ethics & Compliance Policy LL.010
\item \textsuperscript{313} MS.12.01.01
\item \textsuperscript{314} MS.12.01.01
\item \textsuperscript{315} MS.04.01.01
\item \textsuperscript{316} MS.01.01.01
\item \textsuperscript{317} LD.04.01.01
\item \textsuperscript{318} MS.01.01.01; LD.01.05.01,
\item \textsuperscript{319} LD.01.03.01
\item \textsuperscript{320} MS.01.01.01
\end{itemize}
The key functions of the Medical Staff shall be performed ongoing through the activities of the Departments, Divisions, and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees. The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the standing committees, the Medical Executive Committee or the President of the Medical Staff may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

10.10. DESIGNATION

The current standing committees of the Medical Staff are the Medical Executive Committee, the Credentials Committee, the Medical Care Review Committee, the Surgical Care Review Committee, the Bylaws Committee, the Nominating Committee, the Institutional Review Board, the Utilization Review Committee, the Pharmacy and Therapeutics Committee, and Quality Council.

10.11. OPERATIONAL MATTERS RELATING TO COMMITTEES

10.11.1. REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation. Medical Staff representatives for a Hospital committee shall be appointed by the President of the Medical Staff with input from the Chief Executive Officer or Chief Medical Officer.

10.11.2. EX OFFICIO MEMBERS

The Chief Executive Officer and Chief Medical Officer shall be ex-officio members of all Medical Staff committees. The Chief Executive Officer may designate another senior administrative Member to attend any meeting in his/her place. At the prerogative of the Board of Trustees, Board Member(s) may be appointed by the Board of Trustees to serve as representative(s) of the Board of Trustees on any Medical Staff committee or Hospital committee. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

10.12. APPOINTMENT OF CHAIRPERSON AND MEMBERS

Within two months prior to the end of each Medical Staff year, the President of the Medical Staff for the coming year with approval of the Medical Executive Committee, shall appoint Medical Staff members to Medical Staff standing committee positions due

---

321 MS.01.01.01; LD.01.05.01, MS.01.01.03, MS.02.01.01,
322 MS.02.01.01
to be vacated at the start of the next Medical Staff year. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, Medical and Surgical Care Review Committee and any other committee performing a professional review activity shall be subject to ratification by the Board per Article Eight, Section 8.3.3 of these Bylaws. The Chief Executive Officer, in consultation and with the approval of the President of the Medical Staff, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

10.13. TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee Member shall be two (2) years. To promote continuity, approximately one half of the committee membership appointments shall commence on the first day of odd-numbered Medical Staff years, and the other half shall commence on even-numbered years.

If a chairperson or member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the President of the Medical Staff, the Medical Executive Committee, or the Board may remove that Member from the committee position. As a condition of serving on a committee, and by virtue of having accepted the appointment, each Member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the Member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

10.14. NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally and may be given not less than three (3) days before the meeting.

10.15. MEETINGS

The frequency of meeting shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee. All business meetings for all committees, subcommittees, Departments, and Divisions shall be held on the campus of the Hospital. Meetings may also be held through secure teleconference or secure web-based technology provided that off-site participants are able to view all of the documentation being presented, are able to interactively participate in the discussion, and are able to cast their vote either verbally, or through an approved alternative, i.e., web-supported voting system, fax, or email as approved by the Hospital.

10.15.1. QUORUM

10.15.1.1. MEDICAL EXECUTIVE COMMITTEE - At least 50% of eligible voting members plus the Chairman shall constitute a quorum for the transaction of business at any Medical Executive Committee meeting.

10.15.1.2. STANDING COMMITTEES OF THE MEDICAL STAFF – A majority of the voting members of a committee present in person, or by interactive telecommunications, at a meeting shall constitute a quorum of the committee.

10.15.2. MANNER OF ACTING

113
The act of a majority of the voting members of a committee present at a meeting at which a quorum is present shall be the act of the committee. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote.

10.15.3. ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee’s written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee.

10.15.4. MINUTES

Each committee and subcommittee shall record minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee’s or subcommittee’s conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years, after which they may be placed in archive storage, for perpetuity.

10.15.5. PROCEDURES

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

10.15.6. REPORTS

Each standing and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part.

10.15.7. COMMITTEES, DEPARTMENTS AND DIVISIONS WITH PEER REVIEW RESPONSIBILITIES

Peer review is the concurrent or retrospective review of an individual’s professional qualifications professional competence, or professional conduct, including through clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.

10.15.7.1. Purpose of Peer Review: The purpose of the Hospital’s peer review processes, programs, and proceedings are to encourage candid discussions in a private and confidential setting among Practitioners, other individuals with clinical privileges and other health care personnel to accomplish the following objectives:

---

323 HCA, Ethics & Compliance Policy EC.014, Record Series Code ADM-90-09
324 42 USC §11135; 42 C.F.R. §482.21(c), Guidance to Surveyors, 42 C.F.R. §482.22(a)(1)
10.15.7.1.1. To improve the quality of health care provided to patients;

10.15.7.1.2. To reduce morbidity and mortality at the Hospital;

10.15.7.1.3. To improve the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Practitioners, other individuals with clinical privileges, and other health care professionals who provide care to patients at the Hospital; and,

10.15.7.1.4. To maintain confidentiality of information generated during the course of peer review processes, programs and proceedings.

10.15.7.2. **Peer Review Information**: All peer review information shall be kept private and confidential. A Practitioner, other individual with clinical privileges, or other Hospital staff Member who participates or has participated in a peer review process at the Hospital shall treat all peer review information as private, confidential and privileged and shall not disclose peer review information obtained, generated or compiled during a peer review process in which he/she participates unless specifically and expressly authorized by the Hospital to do so or as required by law.

10.15.7.3. **Hospital Committees or Functions**: A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: patient safety, performance improvement, utilization management, credentialing, infection control, review of use of operative and invasive procedures, review of medical records, review of use of medications, review of use of blood and blood components, clinical risk management, quality assessment, any other review or investigation of professional performance or conduct, and fair hearings conducted pursuant to the Medical Staff Fair Hearing Plan.

10.15.7.4. **Circumstances for Peer Review**: The primary purpose of peer review activities shall be to improve an individual’s performance. Peer review analysis shall be conducted whenever data comparisons indicate that the level of an individual’s performance patterns or trends vary substantially from the expected.\(^{325}\) Peer review shall also be conducted for unanticipated adverse events when root cause analysis indicates human factors related to an individual’s performance are possibly significant to the cause of the event.\(^{326}\) Peer review may be conducted for other reasons including, but not limited to, situations involving an individual case that may fall

---

\(^{325}\) PI.02.01.01
\(^{326}\) PI.02.01.01
outside the standard of care, or failure to comply with Hospital policies and procedures, or in any other circumstance deemed necessary by the President of the Medical Staff, Chief Executive Officer, Medical Executive Committee, or any other committee authorized to review of evaluate an individual’s performance, or the Board of Trustees. An external reviewer or review panel may be used when the Medical Staff lacks necessary expertise, or when there is a question of conflict of interest, or when additional review is needed to confirm peer review results, or in any other circumstance in which external review is deemed necessary by the President of the Medical Staff, Chief Executive Officer, Medical Executive Committee, or any other committee authorized to review of evaluate an individual’s performance, or the Board of Trustees. 327

10.15.7.5. **Peer Review Panel:** Professional review shall be conducted by a professional review body (e.g., a committee with a designated peer review function or an ad hoc peer review panel), any person acting as a Member or staff to a professional review body, or any person under contract with a professional review body. 328 Ad hoc peer review panels may be selected for specific focused review by the President of the Medical Staff, Chief Executive Officer, Medical Executive Committee, any other Medical Staff committee authorized to review or evaluate care, or the Board of Trustees. 329

10.15.7.6. **Timeframes for Review:** Focused peer review activities shall be conducted and the results reported within a timeframe of no more than 90 days. In circumstances requiring ongoing review before a determination can be made, an interim report may be submitted within the defined timeframe if the final report will not be completed within the defined timeframe. 330

10.15.7.7. **Participation in Review:** The individual whose performance or conduct is being reviewed shall have an opportunity to participate in the peer review process, either through attendance at a meeting in which the peer review results are discussed, in interviews with peer reviewers, or any other form of communication or correspondence with peer reviewers or the peer review panel. If the individual has been offered an opportunity to participate but the individual decides not to participate, the review may be concluded and final results reported without the participation of the individual. 331

10.15.7.8. **Records and Minutes:** The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. Peer review records and

---

327 MS.08.01.01; MS.08.01.03; MS.09.01.01
328 HCQIA, §11111(a)(1)(A-C)
329 MS.08.01.01; MS.08.01.03; MS.09.01.01
330 MS.08.01.01; MS.08.01.03; MS.09.01.01
331 MS.08.01.01; MS.08.01.03; MS.09.01.01
information will be identified with a conspicuous notation or stamp, for example: CONFIDENTIAL PEER REVIEW INFORMATION. The names of individuals who present or provide information during a peer review process should be documented.

10.15.7.9. **Credentialing Records**: The credentialing record or file of each Practitioner or other individual with clinical privileges shall be subject to the peer review privilege and maintained separately and identified as peer review information.

10.15.7.10. **Custody**: Peer review information, including Medical Staff records, shall be maintained under the custody of the President of the Medical Staff and the Chief Executive Officer.

10.15.7.11. A Practitioner or other individual with clinical privileges shall be permitted access to further information in the credentials and peer review file only if, following a written request by the individual, the Chief Executive Officer, in consultation with the President of the Medical Staff and legal counsel, finds that the individual has a compelling need for such information and grants written permission. A Practitioner or other individual with clinical privileges shall be permitted access to further information in that credentials file only if, following a written request by the individual, the Medical Executive Committee and the Board find that the individual has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested; whether the release of information might have an adverse effect on the Hospital, the Medical Staff, the individual or other persons; whether the information could be obtained in a less intrusive manner; whether the information was provided to the Hospital in specific reliance upon continued confidentiality; whether a harmful precedent might be established by the release; and such other factors as might be considered appropriate. The Medical Executive Committee or the Board may enforce restrictions or conditions if access is permitted.

10.15.7.12. **Medical Staff Officers**: Members of the Board, licensing agencies, accreditation and regulatory authorities, the Chief Executive Officer, counsel to the Hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and official functions. The Board and the Chief Executive Officer and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions.
10.15.7.13. **Outside Requests for Information:** The Medical Staff Office and the President of the Medical Staff (or his designee) may release information contained in Medical Staff files in response to a proper request from another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. The request must include information that the Practitioner or other individual with clinical privileges is a Member of the requesting facility’s medical staff or has been granted privileges at the requesting facility, or is an applicant for medical staff membership or clinical privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.

10.15.7.14. **Reporting Obligations:** If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes.

10.15.7.15. **Surveyor Review:** Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff records on the Hospital premises in the presence of Medical Staff personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or other legal requirements, (b) access is provided only with the concurrence of the Chief Executive Officer (or his/her designee) and the President of the Medical Staff (or his/her designee), and (c) the surveyor demonstrates the following to the satisfaction of the Chief Executive Officer or President of the Medical Staff:

10.15.7.15.1. Specific statutory, regulatory or other appropriate authority to review the requested materials;

10.15.7.15.2. The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;

10.15.7.15.3. The materials sought are the most direct and least intrusive means to accomplish the purpose;

10.15.7.15.4. Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital;

10.15.7.15.5. If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate,
and information will be kept confidential to the maximum extent permitted by law.

10.15.7.16. **Subpoenas:** All subpoenas of Medical Staff records shall be referred to the Chief Executive Officer and the President of the Medical Staff.

10.15.7.17. **Legal Counsel:** Legal counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.

10.15.7.18. **Other Requests:** All other requests by persons or organizations for information contained in Medical Staff records shall be forwarded to the Chief Executive Officer and the President of the Medical Staff for evaluation.

10.15.7.19. **Peer Review Meetings:** All peer review functions shall be performed only at meetings held on the campus of the Hospital.

10.16. **MEDICAL EXECUTIVE COMMITTEE**

10.16.1. **COMPOSITION**

The voting Members of the Medical Executive Committee shall be fully licensed, Active physician members of the Medical Staff. The membership shall consist of the President of the Medical Staff, the President of the Medical Staff-Elect, the Immediate Past President of the Medical Staff, the Secretary/Treasurer, the Chairpersons of each Medical Staff Department, the Chairperson of the Credentials Committee, representation from the Critical Care and Hospitalist Divisions, the Chief Medical Officer, and Chief Executive Officer. The Chief Medical Officer and Chief Executive Officer shall be ex-officio members without a vote. No Active Medical Staff Member in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. The President of the Medical Staff shall serve as the chairperson of the committee.

10.16.2. **DUTIES AND AUTHORITY**

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The Medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies to address the details for describing, implementing, enforcing or otherwise carrying out the provisions contained within these Bylaws. The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws in Sections 10.1.1 and 10.1.2, and

---

332 MS.01.01.01; 42 C.F.R. §482.22(b)(2); MS.02.01.01
333 MS.02.01.01
334 MS.02.01.01
335 MS.02.01.01
336 MS.01.01.01
oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

10.16.2.1. Providing for current Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies, subject to the approval of the Board;

10.16.2.2. To periodically review the Medical Staff Bylaws, Rules and Regulations and make recommended revisions thereto in order to reflect the Hospital’s current policies with respect to Medical Staff organization and function;

10.16.2.3. Implement policies of the Medical Staff not otherwise the responsibility of the department;

10.16.2.4. Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.

10.16.2.5. Collaborate with other leaders of the organization in Hospital planning.

10.16.2.6. To coordinate the activities and general policies of the various departments;

10.16.2.7. To make recommendations to the Chief Executive Officer on matters of medico-administrative nature;

10.16.2.8. To make recommendations on Hospital management matters to the Medical Staff, Board of Trustees, and the Chief Executive Officer;

10.16.2.9. To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

10.16.2.10. To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;

10.16.2.11. To report at each general Medical Staff meeting;

10.16.2.12. To review the recommendations from the Credentials Committee regarding establishment of written criteria, make recommendations from the Medical Executive Committee and forward to the Board of Trustees for final approval;

10.16.2.13. To review the recommendations of the Credentials Committee concerning all applications, and to make written comment to the Board of Trustees on the recommendations from the Credentials Committee regarding appointment, assignments to services, and delineation of clinical privileges;

10.16.2.14. To review periodically all information of Medical Staff appointees and other Practitioners with clinical privileges, including, but not limited to focused professional practice evaluation data, ongoing professional practice evaluation data, peer review Information and credentialing data, and, as a result of such reviews, make recommendations for reappointments and renewal or changes to clinical privileges;

10.16.2.15. To take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all
appointees of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

10.16.2.16. To review the qualifications, evidence of current competence, and the recommendations of a Department Chairperson and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment, reappointment, Medical Staff category, assignment to Departments and Divisions, clinical privileges, and any disciplinary actions;

10.16.2.17. To organize the Medical Staff’s quality assessment/performance improvement activities, including the review of the safety, effectiveness, patient-centeredness, equitability, efficiency, and timeliness of medical and surgical care, and establishing mechanisms designed to conduct, evaluate, and revise such activities;

10.16.2.18. To conduct and supervise Medical Staff professional review activities;

10.16.2.19. To receive and act on reports and recommendations from Medical Staff committees, Departments, and assigned activity groups, inclusive of, but not limited to reports of Medical Staff quality assessment and performance improvement activities;

10.16.2.20. To fulfill the Medical Staff’s accountability to the Board of Trustees for the medical care rendered to patients in the Hospital; and,

10.16.2.21. To make recommendations directly to the Board of Trustees with regard to all of the following:

10.16.2.21.1. The Medical Staff structure;

10.16.2.21.2. The mechanism used to review credentials and to delineate individual clinical privileges;

10.16.2.21.3. Recommendations of individuals for Medical Staff membership;

10.16.2.21.4. Recommendations for delineated clinical privileges for each eligible individual.

337 IOM, Crossing the Quality Chasm, six aims for improving healthcare

338 MS.01.01.01, MS.02.01.01, MS.05.01.01, MS.05.01.03, MS.10.01.01

339 MS.02.01.01

340 MS.02.01.01

341 MS.02.01.01

342 MS.02.01.01

343 MS.02.01.01

344 MS.02.01.01
10.16.2.21.5. The participation of the Medical Staff in organization quality assessment, performance improvement, and patient safety activities;\textsuperscript{345}

10.16.2.21.6. Reports regarding the Medical Staff’s evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;\textsuperscript{346}

10.16.2.21.7. The mechanism by which Medical Staff membership may be terminated; and,\textsuperscript{347}

10.16.2.21.8. The mechanism for fair hearing procedures.\textsuperscript{348}

10.16.22. Report at each Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff.

10.16.3. MEETINGS AND REPORTING

The Medical Executive Committee shall meet at least ten (10) times annually, and shall report the activities of the Medical Staff and the Medical Executive Committee to the Board.\textsuperscript{349}

10.17. CREDENTIALS COMMITTEE

10.17.1. COMPOSITION

The Credentials Committee shall be composed of voting members who shall be Active Staff Members in good standing appointed as described in Section 10.4.3. The voting membership shall include a minimum of five active staff members appointed by the President of the Medical Staff. In addition, the Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Director of Medical Staff Office, Director of Quality Management shall be ex-officio members without vote.

10.17.2. DUTIES AND AUTHORITY

The Credentials Committee shall perform the key function of Credentialing, as described in these Bylaws in Section 10.1.3, under the oversight and direction of the Medical Executive Committee. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of clinical privileges and make recommendations as to whether the applicants meet the Medical Staff’s criteria for membership and/or clinical privileges. In addition, the following specific functions shall be performed by the Credentials Committee:

\textsuperscript{345} MS.05.01.01, MS.05.01.03 \\
\textsuperscript{346} 42 C.F.R. §482.12(a)(5); 42 C.F.R. §482.22.(b) \\
\textsuperscript{347} MS.02.01.01 \\
\textsuperscript{348} MS.10.01.01 \\
\textsuperscript{349} MS.02.01.01
10.17.2.1. Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing.\(^{350}\)

10.17.2.2. Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges.\(^{351}\)

10.17.2.3. Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.\(^{352}\)

10.17.2.4. Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.

10.17.2.5. Investigate the credentials of all applicants for Medical Staff appointment or clinical privileges;

10.17.2.6. Make recommendations to the Medical Executive Committee concerning applications for initial appointment, granting of clinical privileges, applications for reappointment, changes in clinical privileges, and changes in Medical Staff category;

10.17.2.7. Solicit recommendations from the clinical Departments concerning written criteria for the granting of clinical privileges within each Department and/or division. The Credentials Committee shall take such departmental recommendations and prepare its own recommendation. Recommendations from the Credentials Committee regarding establishment of written criteria shall be forwarded to the Medical Executive Committee for their recommendations and to the Board of Trustees for final approval;

10.17.2.8. Determine whether a reduction in Medical Staff category for a Medical Staff member is warranted because of failure to meet the patient care requirements set forth in the Medical Staff Bylaws, or failure to meet the attendance requirements set forth in the Medical Staff Bylaws, or it is not warranted due to extraordinary circumstances;

10.17.2.9. Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing.\(^{353}\)

10.17.2.10. Through making recommendations related to granting clinical privileges, ensure that the same quality of care is provided to patients by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and

\(^{350}\) MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03

\(^{351}\) LD.3.20; MS.01.01.01; LD.01.05.01

\(^{352}\) MS.08.01.03

\(^{353}\) MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03
between members and non-members of the Medical Staff who have delineated clinical privileges.\textsuperscript{354}

10.17.2.11. Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.\textsuperscript{355}

10.17.2.12. Make recommendations to the Medical Executive Committee with regard to any revisions in the process or procedures for appointment, reappointment or delineation of clinical privileges.

10.17.3. AVOIDING CONFLICT OF INTEREST

Whenever an applicant’s or Medical Staff member’s practice is in direct economic competition with the practice of a member of the Credentials Committee, such member of the Credentials Committee who is in direct economic competition with the Applicant or Medical Staff member shall abstain from voting during proceedings involving the applicant or Medical Staff member. Such abstention shall be recorded in the minutes of the meeting.\textsuperscript{356}

10.17.4. MEETINGS AND REPORTING

The Credentials Committee shall meet at least ten (10) times annually, and shall report their recommendations and activities to the Medical Executive Committee.\textsuperscript{357}

10.18. QUALITY COUNCIL

10.18.1. COMPOSITION

The Quality Council shall be composed of Members of the Medical Staff, Senior Management, Quality and Risk employees and other Directors as appointed.

Medical Staff members shall include: President of the Medical Staff, Vice President of the Medical Staff, and other members of the Medical Staff appointed by the President of the Medical Staff. The Chairman shall be appointed by the President of the Medical Staff.

Senior Management shall include: Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, Chief Financial Officer, Assistant Chief Nursing Officers, and Service Line Administrators.

Directors shall include: Quality, Risk Management and Medical Staff Services.

Other representatives shall include: Infection Preventionist, Risk Manager, Medical Staff Coordinator and others as indicated by agenda items.

The voting membership shall include all assigned and appointed Medical Staff and Hospital Staff members/representatives.

10.18.2 DUTIES AND AUTHORITY

\textsuperscript{354} LD.04.03.07; MS.01.01.01; LD.01.05.01

\textsuperscript{355} MS.08.01.03


\textsuperscript{357} MS.02.01.01
The Quality Council provides oversight of the quality of healthcare services provided by Capital Regional Medical Center and assists in the integration of information needed to make decisions and formulate effective action plans.

In addition, the responsibilities of the Quality Council include:

10.18.2.1. Review of patient safety and performance improvement data. Evaluate current action plans and make recommendations as needed to improve effectiveness.

10.18.2.2 Annual approval of Performance Improvement Plan, Patient Safety Plan and Performance Improvement/Patient Safety Annual Evaluation. Ensure that Plans are implemented effectively.

10.18.2.3 Ensure that all Joint Commission required measures and National Patient Safety Goals are monitored and actions are taken to improve compliance.

10.18.3 MEETINGS AND REPORTING

The Quality Council shall meet at least quarterly, and shall report their activities to the Board of Trustees through the Medical Executive Committee.

10.19. MEDICAL CARE REVIEW COMMITTEE

10.19.1. COMPOSITION

The Medical Care Review Committee shall be composed of voting members who shall be Active staff members in good standing representing the departments of Medicine, Radiology, and Emergency Medicine who are appointed by the President of the Medical Staff, as described in Section 10.4.3 in these Bylaws. In addition to the Chief Executive Officer, Chief Medical Officer and Chief Nursing Officer, the ex-officio members without vote shall include the Director of Quality Management and the Risk Manager. The Medical Care Review Committee shall also have the option of calling upon any Member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the President of the Medical Staff acting on behalf of the Medical Executive Committee and the Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of Article Eight, Section 8.3.3. Ad hoc members of the committee shall not have voting rights on the committee

10.19.2. DUTIES AND AUTHORITY

The Medical Care Review Committee shall perform the key function of Quality Assessment/Performance Improvement for the Departments of Medicine, Radiology, and Emergency Medicine as described in these Bylaws in Section 10.1.4, under the oversight and direction of the Medical Executive Committee. The Medical Care Review Committee shall plan, implement, coordinate and promote ongoing Medical Staff leadership and participation in the Hospital’s performance improvement program through the activities of the Medical Staff Departments, committees with a quality review function, and other assigned activity groups, as described in the Performance Improvement Plan.

358 MS.02.01.01
Additionally, the Medical Care Review Committee shall ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual’s performance, the committee shall conduct peer review or an ongoing evaluation of the individual’s competence and make recommendations accordingly. In addition, the Medical Care Review Committee shall perform the following specific functions:

10.19.2.1. Participate in an annual evaluation of the Hospital’s Performance Improvement program and in the development or revisions to the Performance Improvement Plan, including making recommendations for the establishment of priorities for the program.

10.19.2.2. Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also ensure that the activities address the scope of patient care provided and are effective by reviewing the reports of the Medical Staff Departments and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

10.19.2.3. Review of cases not meeting generic screening criteria; monitor trends and outcomes associated with diagnoses related practice parameters; complications; mortality, use of blood and blood products.

10.19.2.3.1. Review of specific invasive procedures for appropriateness of the procedure(s); preparation of the patient for the procedure; performance of the procedure; and intra-procedural monitoring of the patient; provision of post-procedural care and patient outcome(s).

10.19.2.3.2. Develop criteria:

- for specific invasive and other medicine reviews;
- to identify types of cases that shall be excluded from review; and

10.19.2.3.3. Generate recommendations when opportunities for improvement are identified in reference to specific practice patterns.

10.19.2.3.4. Perform other such duties as assigned by the President of the Medical Staff.

10.19.3. MEETINGS AND REPORTING

---

359 MS.05.01.03; 42 C.F.R. §482.22(a)(1)
360 LD.03.03.01; LD.03.05.01; LD.04.04.01; PI.03.01.01
The Medical Care Review Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.\textsuperscript{361}

10.20. SURGICAL CARE REVIEW COMMITTEE

10.20.1. COMPOSITION

The Surgical Care Review Committee shall be composed of voting members who shall be Active staff members in good standing representing the departments of Surgery, Anesthesia, Maternal/Child and Pathology, who are appointed by the President of the Medical Staff, as described in Section 10.4.3 of these Bylaws. In addition to the Chief Executive Officer, Chief Nursing Officer and the Chief Medical Officer, the ex-officio members without vote shall also include the Director of Quality Management and the Risk Manager. The Surgical Care Review Committee shall also have the option of calling upon any Member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the President of the Medical Staff acting on behalf of the Medical Executive Committee and the Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of Article Eight, Section 8.3.3. Ad hoc members of the committee shall not have voting rights on the committee.

10.20.2. DUTIES AND AUTHORITY

The Surgical Care Review Committee shall perform the key function of Quality Assessment/Performance Improvement, for the departments of Surgery, Anesthesia, Maternal/Child and Pathology, as described in these Bylaws in Section 10.1.4, under the oversight and direction of the Medical Executive Committee. The Surgical Care Review Committee shall plan, implement, coordinate and promote ongoing Medical Staff leadership and participation in the Hospital’s performance improvement program through the activities of the Medical Staff Departments, committees with a quality review function, and other assigned activity groups, as described in the Performance Improvement Plan. Additionally, the Surgical Care Review Committee shall ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual’s performance, the committee shall conduct peer review or an ongoing evaluation of the individual’s competence and make recommendations accordingly.\textsuperscript{362} In addition, the Surgical Care Review Committee shall perform the following specific functions:

10.20.2.1. Participate in an annual evaluation of the Hospital’s Performance Improvement program and in the development or revisions to the Performance Improvement Plan, including

\textsuperscript{361} MS.02.01.01
\textsuperscript{362} MS.05.01.03; 42 C.F.R. §482.22(a)(1)
making recommendations for the establishment of priorities for the program.  

10.20.2.2. Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also ensure that the activities address the scope of patient care provided and are effective by reviewing the reports of the Medical Staff Departments and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

10.20.2.3. The duties of the Surgical Care Review Committee shall include:

10.20.2.3.1. To review invasive and operative procedures (tissue and non-tissue) for adherence to clinical practice parameters;

10.20.2.3.2. Trends associated with complications/mortality; use of blood and blood products, use of anesthesia/sedation; performance of procedures; provision of pre/post care and outcome trends and cases not meeting generic screening criteria.

10.20.2.3.3. To develop criteria to identify types of cases that shall be excluded from review and to identify other cases for more intensive evaluation.

10.20.2.3.4. Perform other such duties as assigned by the President of the Medical Staff.

10.20.2.3.5. Generate recommendations when opportunities for improvement are identified in reference to specific practice patterns.

10.20.3. MEETINGS AND REPORTING

The Surgical Care Review Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.  

10.21. UTILIZATION REVIEW/RESOURCE MANAGEMENT COMMITTEE

10.21.1. COMPOSITION

The Utilization Review/Resource Management Committee shall consist of at least three (3) members of the Medical Staff and representatives from Nursing Service, HIM, Case Management and Administration.

10.21.2. DUTIES AND AUTHORITY

The duties and authority of the Utilization Review/Resource Management Committee shall include:

---

363 LD.03.03.01; LD.03.05.01; LD.04.04.01; PI.03.01.01
364 MS.02.01.01
10.21.2.1. To establish and carry out a concurrent review program that fulfills the requirements of The Joint Commission and CMS.

10.21.2.2. To monitor and supervise review activities.

10.21.2.3. To act upon cases of inappropriate or questionable patterns of care reported by the Physician Advisor and/or Case Management Staff.

10.21.2.4. To make recommendations for Medical Staff corrective action protocols.

10.21.2.5. To recommend changes in hospital procedures or Medical Staff practices as indicated by analysis of review findings.

10.21.2.6. To hear any appeal of any attending physician regarding decisions of the Physician Advisor.

10.21.2.7. Provide oversight to the functions of Health Information Management (HIMS).

10.21.2.8. Perform such other duties as assigned by the President of the Medical Staff.

10.21.3. MEETINGS AND REPORTING
The Utilization Review/Resource Management Committee shall meet at least quarterly and shall report the activities of the Committee to the Quality Council.

10.22. BYLAWS COMMITTEE
10.22.1. COMPOSITION
The Bylaws Committee shall be composed of voting members who shall be active staff members in good standing. The voting membership shall include the Immediate Past President of the Medical Staff who shall chair the committee, the President of the Medical Staff-Elect, and one active staff Member from each Department. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote shall also include the Director of the Medical Staff Office.

10.22.2 DUTIES AND AUTHORITY
The Bylaws Committee shall perform the key function of Bylaws Review and Revision, as described in these Bylaws in Section 10.1.6, under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws and the Rules and Regulations and recommend any needed additions, revisions, modifications, amendments or deletions. The Bylaws Committee shall also review all Department rules and regulations.

10.22.3. MEETINGS AND REPORTING
The Bylaws Committee shall meet at least annually, and shall report their recommendations and activities to the Medical Executive Committee.

10.23. INSTITUTIONAL REVIEW BOARD
10.23.1. COMPOSITION
The Institutional Review Board shall consist of physicians representing the Medical Staff Departments and representatives from the Pharmacy Department.

365 MS.02.01.01
Laboratory, Nursing, Chaplaincy, Administration and the Risk Manager. The IRB may not consist entirely of men or entirely women.

10.23.2. DUTIES AND AUTHORITY
The duties and authority of the Institutional Review Board shall include:

10.23.2.1. To evaluate and approve protocols concerned with the use of investigational or experimental drugs and medical devices.

10.23.2.2. Perform other such duties as assigned by the President of the Medical Staff.

10.23.2.3. The Institutional Review Board shall meet on an on-call basis, but not less than once per year.

10.23.3. MEETINGS AND REPORTING
The Institutional Review Board shall meet at least annually, and shall report the activities of the IRB to the Board of Trustees.

10.24. NOMINATING COMMITTEE

10.24.1. COMPOSITION
The Nominating Committee shall be composed of voting members who shall be active staff members in good standing. The voting membership shall include the President of the Medical Staff who shall chair the meeting, the Immediate Past President of the Medical Staff, and one active staff Member from each Department. The Chief Executive Officer and the Chief Medical Officer shall serve as ex-officio members without vote. No candidate for election may serve as a Member of the Nominating Committee.

10.24.2. DUTIES AND AUTHORITY
The Nominating Committee shall perform the key function of Nominating, as described in these Bylaws in Section 10.1.7 and Section 8.3.1, under the oversight and direction of the Medical Executive Committee. The Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election of officers.

10.24.3. MEETINGS AND REPORTING
The Nominating Committee shall meet at least every two years during an election year, and shall report their recommendations and activities to the Medical Executive Committee.

10.25. PHARMACY AND THERAPEUTICS COMMITTEE

10.25.1. COMPOSITION
The Committee will include, at a minimum, the following representation: medical staff, administration, pharmacy, nursing, dietary, laboratory, other clinical department handing therapeutic or diagnostic agents, risk management or quality management, anesthesia, and the emergency department.

10.25.2. DUTIES AND AUTHORITY
The duties of the Committee will include:
10.25.2.1. Develop and approve all policies and procedures relating to the procurement, storage, distribution, use and administration of drugs and diagnostic testing materials.

10.25.2.2. Develop and maintain the hospital specific drug formulary by analyzing the needs of the organization’s patient populations, efficacy, utilization, existing like drugs, safety, effectiveness and cost.

10.25.2.3. Develop an approved definition of an adverse drug reaction and review all untoward events in accordance with the definition. Monitor for trends and opportunities to reduce drug reaction risk.

10.25.2.4. Develop, approve and communicate the definition of a medication error. Supervise the mechanism to report and analyze medication errors for opportunities to improve the medication process. Control, safety and to provide oversight and recommendations for the necessary education.

10.25.2.5. Develop, maintain and analyze a medication usage program for opportunities to improve medication utilization, safety, appropriateness and effectiveness. The program should be based on approved review criteria with a focus on high volume, high risk and problem prone. Measuring the prescribing, orders, preparation, dispensing and administration of selected therapeutics.

10.25.2.6. Review and develop policies regarding the therapeutic agents to be stocked on the nursing units and other departments; considering safety, packaging, volumes and maintaining control.

10.25.2.7. Develop a list of high risk medications and define policy on the handling, storage, distribution and administration of the medications to provide for a safe environment.

10.25.2.8. Develop and monitor the control and safety of medication processes as they related to controlled substances.

10.25.2.9. Review and monitor the appropriateness of antibiotics used within the hospital.

10.25.2.10. Develop and review standards involving the use, control and cost of investigational drugs and of research in the use of FDA approved drugs.

10.25.2.11. Develop a mechanism to efficiently and safely manage all medication recalls and to monitor patient care/safety outcomes as they relate to the specific drugs recalled.

10.25.2.12. Develop mechanisms to educate and analyze the effectiveness of the education related to, but not limited to the following: new drugs, drug recalls, drug warnings, drug shortages, cost variations and efficacy, appropriateness, and packing and dosing issues, policy change medication safety and reporting.

10.25.3. MEETINGS AND REPORTING
The Pharmacy & Therapeutics Committee shall meet as frequently as necessary to fulfill the functions but not less than quarterly, and shall report the activities of the Committee to the Medical Executive Committee.

10.26. CANCER COMMITTEE

10.26.1. COMPOSITION

The Cancer Committee shall consist of at least five (5) members of the Medical Staff; (at least one diagnostic radiologist, one surgeon, one pathologist, one medical oncologist and one radiation oncologist); one physician member will be designated as the Cancer Liaison Physician; the Cancer Program Administrator and representatives from Nursing Oncology, Case Management, Performance Improvement and HIMS (Certified Tumor Registrar), Administration and other disciplines as appropriate, such as Pharmacy, Nutrition, Pastoral Care and community resource and lay members.

10.26.2. DUTIES AND AUTHORITY

The Cancer Committee is responsible and accountable for goal setting, planning, designing, initiating, implementing, evaluating and improving all cancer related service activities at Capital Regional Medical Center. The Cancer Committee develops, monitors and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and overall program activities of cancer care service.

The duties of the Cancer Committee include:

10.26.2.1. Providing program leadership for all aspects of oncology care
10.26.2.2. Providing direction for cancer program activities and serve as the basis for cancer program evaluation
10.26.2.3. Establishing, monitoring and evaluating the cancer conference frequency and format
10.26.2.4. Establishing, monitoring and evaluating the multidisciplinary attendance requirements for cancer conferences
10.26.2.5. Ensuring that the required number of cases are discussed at the cancer conference on an annual basis and that at least 75% of the cases discusses are presented prospectively
10.26.2.6. Establishing and implementing a plan to evaluate the quality of the cancer registry data and activity
10.26.2.7. Analyzing patient outcomes and disseminating the results
10.26.2.8. Developing recommendations for providing care and improving coordination of care
10.26.2.9. Implementing two improvements annually that directly affect cancer patient care
10.26.2.10. Facilitating two community outreach prevention or early detection programs annually
10.26.2.11. Ensuring that all requirements are met for accreditation by the American College of Surgeons Commission on Cancer.

10.26.3. MEETING AND REPORTING

The Cancer Committee shall meet at least quarterly, and shall report the activities of the Committee to the Quality Council.
11. **ARTICLE ELEVEN: MEETINGS**

11.1. **MEDICAL STAFF YEAR**

The Medical Staff year shall be the period from January 1 to December 31 of each year.

11.2. **MEDICAL STAFF MEETINGS**

11.2.1. **REGULAR MEETINGS**

The regular meeting of the Medical Staff shall be held twice per year, at a time and place designated by the Medical Executive Committee, for the purpose of receiving reports from officers and committees, electing officers, and transacting other such business as may properly come before the meeting of the Medical Staff.

11.2.2. **SPECIAL MEETINGS**

Special meetings of the Medical Staff may be called at the direction of the President of the Medical Staff and shall be called by the President of the Medical Staff at the request of the Medical Executive Committee or any ten members of the active staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.2.3. **DEPARTMENT AND DIVISION MEETINGS**

Regular meetings of each Department shall be held at least twice per year, or more frequently as necessary to perform the functions of Departments as specified in Article Nine of these Bylaws. The Divisions shall meet as often as necessary to perform Division functions.

11.3. **ATTENDANCE REQUIREMENTS**

11.3.1. **GENERALLY**

Active staff members of the Medical Staff shall be required to attend fifty percent (50%) of the meetings of the Department to which they are assigned, and fifty percent (50%) of bi-annual general staff meetings. Attendance shall be considered at the time of reappointment when evaluating whether a Member has met the obligations associated with Medical Staff membership.

11.3.2. **SPECIAL APPEARANCES**

A Medical Staff Member or other individual with clinical privileges may be required to attend a meeting of a Medical Staff Committee for purposes of conducting peer review. Following receipt of proper notice of such an attendance requirement, failure to attend may be grounds for suspension, termination, or other actions on Medical Staff membership or clinical privileges.

11.4. **MEETING PROCEDURES**

11.4.1. **NOTICE OF MEETINGS**

Notice of the date, time and place of the bi-annual Medical Staff meetings shall be given not less than seven (7) days or more than thirty one (31) days prior to a regular meeting, and not less than three (3) days prior to a special meeting of the General Medical Staff by written notice delivered personally or sent by mail or electronically to each Member of the active staff at his/her address as shown in Medical Staff records. The Medical Executive Committee or the President of the
Medical Staff may send notice to members of other categories of the Medical Staff, the Chief Executive Officer, members of Administration and others. If mailed, notice shall be deemed to be delivered when deposited in the United States mail, postpaid.

Notice to a Medical Staff Member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting.

11.5. QUORUM

11.5.1. GENERAL STAFF MEETINGS

At least twenty percent (20%) of the non-provisional active staff members present in person shall constitute a quorum for the transaction of business at any General Medical Staff meeting, except if less than such a number is present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

11.5.2. DEPARTMENT OR DIVISION MEETINGS

At least one-third of the non-provisional active staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff Department or Division meeting, except if less than such a number is present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

11.5.3. MANNER OF ACTION

The act of a majority of the voting members present at a general Medical Staff meeting at which a quorum is present shall be the act of the Medical Staff. The act of the majority of voting Department members present at a Medical Staff Department meeting at which a quorum is present shall be the act of the Department.

11.5.4. VOTING RIGHTS

Only non-provisional status active staff members have the right to vote. A non-physician Member of the Medical Staff may vote on credentialing matters (such as procedures for appointment, reappointment, granting clinical privileges and discipline) only when such matters involve practitioners who hold the same professional license as the non-physician.

11.5.5. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided.

11.6. MINUTES

The Secretary/Treasurer shall prepare minutes of each meeting of the Medical Staff, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the Secretary/Treasurer, approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of
records and information. Each Department Chairperson and each Division Director shall ensure that minutes are prepared for their respective Department or Division meetings.

11.7. PROCEDURAL RULES
The President of the Medical Staff, or in his/her absence, the President of the Medical Staff-Elect, shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert’s Rules of Order, as may be modified by the Medical Staff.

12. ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY AND RELEASE

12.1. AUTHORIZATIONS AND CONDITIONS
Any applicant for Medical Staff membership or clinical privileges and every Member of the Medical Staff or individual with clinical privileges shall agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

12.2. CONFIDENTIALITY OF INFORMATION
Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the Chief Executive Officer, Administrative officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a Member of the Medical Staff, authorized representatives of the Staff, the Administration or the Board.

12.3. BREACH OF CONFIDENTIALITY
Inasmuch as effective peer review, credentialing and quality assessment/performance improvement activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, Department, or committee is outside appropriate standards of conduct for this Medical Staff and shall be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach of confidentiality shall subject the individual responsible for a breach or threatened breach of confidentiality to disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

12.4. IMMUNITY FROM LIABILITY
The Board of Trustees, any committees of the Medical Staff and/or of the Board of Trustees who conduct Professional Review Activities and any individuals within the Hospital authorized to conduct Professional Review Activities, hereby constitute
themselves as Professional Review Bodies as defined in the Health Care Quality Improvement Act of 1986 and in the State of Florida's Peer Review Protection Act (FS766.1015, 780.1016). Each Professional Review Body hereby claims all privileges and immunities afforded to it by said federal and state statutes. Any action taken by a Professional Review Body pursuant to these Medical Staff Bylaws shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any Applicant or Medical Staff Appointee, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from, nor shall any legal action be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

12.4.1. Applications for appointment to the Medical Staff or for clinical privileges;
12.4.2. Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;
12.4.3. Corrective action or disciplinary action, including suspension, probation, limitation or revocation of Medical Staff membership or clinical privileges;
12.4.4. Hearing and appellate review;
12.4.5. Medical care evaluations;
12.4.6. Peer review evaluations;
12.4.7. Utilization review and resource management; and,
12.4.8. Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person’s professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

12.5. RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff Member or individual with clinical privileges shall, by requesting or accepting membership or clinical privileges, release and discharge from loss, liability, cost, damage and expense, including attorney’s fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon the request of the Hospital or any officer of the Medical Staff, execute a written release in accordance with the tenor and import of this Article.

12.6. SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

12.7. NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

13. ARTICLE THIRTEEN: ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

13.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions. The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards. The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. Notwithstanding anything to the contrary contained herein the Board shall maintain complete and ultimate responsibility and authority over the operation of the Medical Staff. In the event the Medical Staff is unable or refuses to amend their Bylaws to comply with local, State or Federal laws and regulations or to address a concern that could adversely affect patient safety or quality of care, the Board retains the authority to unilaterally amend the Medical Staff Bylaws or Rules & Regulations in such situation after first exhausting reasonable efforts to gain Medical Staff approval, including using the Hospital’s conflict resolution process. The Board provides and supports a system for resolving conflicts among the Medical Staff Members, the Medical Executive Committee and the Hospital administration. The potential exists for conflicts to arise from time to time among those who participate in making decisions regarding operational, medical, social, or financial matters on behalf of the Hospital, the Medical Staff and/or the Hospital’s patients. The Board, in order to resolve all conflicts fairly and objectively, whether the conflict is between administrators, managers, Medical Staff Members, employees or the governors of this hospital may appoint a Conflict Resolution Committee made up of Members of the Board, Members of the Medical Staff, Members of the Medical Executive Committee and the Chief Executive Officer or his/her designee. The purpose of the Conflict Resolution Committee is to promote

---

368 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c)
369 42 C.F.R. §482.12(a)(3), Interpretive Guidelines
370 HCA, Model Governance Bylaws, 42 C.F.R. §482.12(a)(4), 42 C.F.R. §482.22(c)(1), MS.01.01.01, MS.01.01.03
resolution and promote decision making that results in the appropriate use of power, protection of human rights and consideration of organizational and societal issues as reflected in the hospital’s mission and values statements. The Conflict Resolution Committee shall make recommendation to the Board for the Board’s consideration and possible action. The Medical Staff Bylaws, Rules and Regulations, and policies shall not conflict with the Bylaws of the Board of Trustees. The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and policies.

13.2 EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

13.3 METHODOLOGY

13.3.1 MEDICAL STAFF BYLAWS

Upon the request of the Medical Executive Committee, or the President of the Medical Staff, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action shall be taken at a regular or special meeting of the Medical Staff, provided that written or electronic notice of the proposed change was sent to all members of the active staff no less than twenty (20) days prior to the meeting at which the Bylaws changes are to be voted upon. The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s). If a quorum is present as described in Article Eleven, Section 11.6.1, for the purpose of enacting a bylaw change, the change shall require an affirmative vote of greater than fifty percent (50%) of the members voting in person or by written or electronic ballot. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff policies, Medical Staff members shall be provided with a revised text.

13.3.2 RULES & REGULATIONS AND MEDICAL STAFF POLICIES

To implement the Medical Staff Bylaws, the Medical Staff shall develop administrative procedures, which shall be described in documents that supplement the Bylaws, such as Rules and Regulations, and policies. If any administrative procedures contained in supplemental documents relate to credentialing, privileging, appointment, reappointment, corrective actions, fair hearing and appeal, the procedures shall be approved by both the Medical Staff and the Board of Trustees through the mechanisms described below. Administrative procedures eligible to be in supplemental documents shall meet the following criteria:

- The administrative procedure is not a step in the process itself;
- The procedure does not have a major impact on the outcome of the process such as procedures that result in an evaluative conclusion or decision;

371 MS.01.01.01
372 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c), MS.01.01.01
373 MS.01.01.01, MS.02.01.01, LD.03.04.01
374 MS.01.01.01
The procedure is not so material to the appropriateness and fairness of the process that it needs to be in the Bylaws.

13.3.2.1 **Medical Staff Rules and Regulations and Policies**: Subject to approval by the Board, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Policies as may be necessary to implement these Bylaws. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governance Bylaws of the Board of Trustees. In the presence of a quorum (see Section 11.6.1.), Medical Staff Members by an affirmative vote of greater than fifty percent (50%) voting in person, in writing or via electronic ballot, may, at a General Staff Meeting or a Special Meeting of the Medical Staff, adopt or amend such Rules and Regulations and Policies as may be necessary to implement these Bylaws. Rules and Regulations and policy changes adopted by the Medical Staff shall become effective following approval by the Board.

13.3.2.2 **Department Rules and Regulations and Policies**: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Board, each Department shall formulate its own Department Rules and Regulations and Policies for the conduct of its affairs and the discharge of its responsibilities. Such Department Rules and Regulations and Policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Policies of the Medical Staff or other policies of the Hospital and shall not conflict with the Governance Bylaws of the Board of Trustees.

13.4 **TECHNICAL AND EDITORIAL AMENDMENTS**

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations.

13.5 **GENERAL PROVISIONS**

13.5.1 **SUCCESSOR IN INTEREST**

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital’s Board or its successor in interest. Until such time as the new bylaws are approved, the existing Bylaws of this Medical Staff shall remain in effect.

13.5.2 **AFFILIATIONS**

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

13.5.3 **NO IMPLIED RIGHTS**

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely
on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

13.5.4. NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

13.5.5. NO CONTRACT INTENDED

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any Member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

Notwithstanding the forgoing, the provisions of Article Thirteen and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

13.5.6. CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. This provision does not prohibit any person from voting for himself/herself nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action.

13.5.7. NO AGENCY

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

13.5.8. CONFLICT

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

13.5.9. ENTIRE BYLAWS
These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.

14. CERTIFICATION OF ADOPTION AND APPROVAL

Approved and Adopted by the Medical Staff of Capital Regional Medical Center on _______________________________________. 20__.

______________________________
PRESIDENT OF THE MEDICAL STAFF

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

Approved and Adopted by the Board of Capital Regional Medical Center on _______________________________________. 20__.

______________________________
CHAIRPERSON OF THE BOARD