



Mercy Medical Center

MEDICAL STAFF BYLAWS

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**BYLAWS OF
THE MEDICAL STAFF
MERCY MEDICAL CENTER, CEDAR RAPIDS, IOWA**

PREAMBLE

WHEREAS, Mercy Medical Center, Cedar Rapids, Iowa, is a non-profit corporation organized under the laws of the State of Iowa; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the hospital and all licensed entities, and must accept and discharge this responsibility, subject to the ultimate authority of the Governing Body, and that the cooperative efforts of the Medical Staff, the CEO and the Governing Body within their respective disciplines are necessary to fulfill the obligations of Mercy Medical Center to its patients;

THEREFORE, the physicians, dentists and podiatrists practicing in this hospital hereby organize themselves into the Medical Staff in conformity with these bylaws.

DEFINITIONS

1. "Adverse Action" - means an action proposed or taken by the Board of Trustees or by the Medical Staff (which could be acting through the Executive Committee or a department), which is reportable to the National Practitioner Databank and/or to the Iowa Board of Medicine upon final action.
2. "Allied Health Practitioner" or "AHP" - means an individual who is permitted by law to provide patient care services as a dependent practitioner or as an independent practitioner. Allied Health Practitioners are not members of the Medical Staff.
3. "Chief Executive Officer" - means the President/CEO, appointed by the Governing Body to act on its behalf in the overall management of the hospital.
4. "Clinical Privileges" or "Privileges" - means the authority granted to render specific patient services, consistent with licensure, education, training and experience, and includes unrestricted access to those hospital resources which are necessary to effectively exercise privileges.
5. "Completed application" - means the submission of all information contained in these bylaws under Article III, Section 1 including a completed list of requested privileges, completion of all required verifications and queries, return of all required references, and resolution of any questions or requests for additional material by the reviewing Department Chairpersons.
6. "Eligible voting member" - means those members of the Medical Staff who are eligible to vote. Voting is limited to members of the active, affiliate and associate Medical Staff.
7. "Governing Body" - means the Board of Trustees of the hospital, or the "Board".

8. "Hospital" or "medical center" - means Mercy Medical Center, Cedar Rapids, Iowa.
9. "In good standing" - means membership and/or privileges are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leave of absence).
10. "Investigation" - means the process initiated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a Medical Staff member, practitioner or other individual holding clinical privileges, and does not include activity of the Medical Staff Wellness Committee.
11. "Medical Executive Committee" or "MEC" - means the executive committee of the Medical Staff.
12. "Medical Staff" - means the organization of those professionals granted membership under these bylaws of the Medical Staff of Mercy Medical Center of Cedar Rapids, Iowa.
13. "Member" - means a medical or osteopathic doctor, dentist or podiatrist holding current membership granted consistent with these bylaws.
14. "Practitioner" - means any individual, not eligible for Medical Staff membership, but granted clinical privileges consistent with Iowa law and these bylaws.
15. "Special Appearance" - means the required attendance and participation of any member or privileges holder at a conference of a Medical Staff committee or department, or with the chair of a Medical Staff committee or department, whenever possible deviation from Medical Staff standards of clinical practice or Medical Staff rules and regulations or policy is identified.
16. "Special Notice" - means written notice sent by U.S. mail, registered with return receipt requested.

ARTICLE I MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership is not automatically granted or denied based solely on the fact that the professional is duly licensed to practice medicine, dentistry or podiatry in this or in any other state, or that he or she is a member of any professional organization, or has in the past, or presently has, such privileges at another hospital; or that the professional has or does not have a contractual, membership, or employment relationship with this or any hospital or system or their subsidiaries or affiliates, or any third-party payor. Economic credentialing is not used in Medical Staff membership or privileging decisions. Medical Staff membership, participation in Medical Staff activities, clinical privileges, and access to resources or patients will not be restricted or terminated or denied because the member's financial or professional interests or plans compete with those of the hospital or system.

Membership will not be denied on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex or sexual orientation, or any other basis prohibited by law. Medical Staff membership is granted only to applicants qualified and credentialed according to these bylaws. Only those holding current membership or temporary privileges granted according to these bylaws may provide medical, osteopathic, dental and podiatric care at the hospital.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP

- a. In order to qualify for membership on the Medical Staff, physicians, dentists and podiatrists must document they are:
 1. currently licensed to practice in the State of Iowa;
 2. graduates of medical, osteopathic, dental or podiatric medical schools accredited by the appropriate nationally recognized accrediting body or recognized by the National Committee on Foreign Medical Education and Accreditation;
 3. graduates of post graduate training programs accredited by the appropriate nationally recognized accrediting body, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and other comparable accreditation bodies. Such consideration shall be based upon the program's standardized supervision, teaching and formal evaluation of the graduate; medical information content; didactic sessions and clinical experience provided.
 4. able to provide evidence to the Medical Staff and Governing Body that the health care services provided by them will be within the scope of their license, in strict conformity with the Medical Staff's standards of care and delivered in a competent, ethical and professional manner. Such evidence shall include information regarding the following: their background, experience, demonstrated competence; and their adherence to the ethic of their profession;

- b. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement to strictly abide by the principles of medical ethics of the American Medical Association or the American Osteopathic Association, or by the code of ethics of the American Dental Association, or the American Podiatric Medical Association, whichever is applicable.
- c. Proof of current malpractice liability insurance is required for membership. This coverage must be provided by an insurer licensed or approved by the Iowa State Insurance Commission. Proof of current coverage must be provided on an annual basis according to the renewal date in order to remain an associate, active, or courtesy member of the Medical Staff. Medical Staff members shall notify the Medical Staff Services office within five business days if liability insurance is reduced, revoked, restricted, or terminated. The MEC may make a recommendation concerning the minimum amount of insurance per claim or medical incident to the Governing Body which will make final determinations regarding the minimum amount of required coverage.

SECTION 3. CONDITIONS AND DURATION OF MEMBERSHIP

- a. The Governing Body shall act on an application for Medical Staff membership for any applicant only after there has been a recommendation from the Medical Staff as provided in these bylaws.
- b. Initial membership terms shall be for a period of one year. Membership renewals shall be for a period of not more than two years.
- c. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement to provide medical coverage in the emergency department in a manner consistent with the Medical Staff member's clinical privileges, if in accordance with the plan developed by the relevant department for such coverage and approved by the MEC regardless of the patient's ability to pay for medical services.
- d. Every application for Medical Staff membership shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his or her patients; to abide by the Medical Staff bylaws, rules and regulations, and policies; and to accept committee, peer review and other Medical Staff assignments. In addition, every application shall contain the applicant's specific agreement (i) to promptly notify Mercy Medical Center Medical Staff office if an event occurs at any time during the course of the applicant's Medical Staff membership that would change the applicant's answer in response to a question regarding his/her health status or professional liability and credentials on the application; (ii) provide requested information to, Mercy Medical Center in relation to such event in a timely manner; and (iii) that failure to timely notify, cooperate with, and provide information to, Mercy Medical Center in relation to such event may constitute cause for corrective action.

- e. Members shall pay annual dues in an amount no less than \$100 set by the MEC at the first meeting of the Medical Staff year. Dues shall be paid no later than the 30th of April. Failure to pay dues by the 30th of April shall be grounds for corrective action.

SECTION 4. MEMBERS' CONFLICTS OF INTERESTS

Medical Staff officers and department chairs, Medical Staff members appointed to chair committees, or serve on the Governing Body, and other members as described herein, shall disclose potential conflicts of interest. Membership and privileges are not affected by any conflict of interest or the declaration of any potential conflict of interest. Exercise of certain Medical Staff obligations and prerogatives may be affected by these conflict of interest requirements.

- a. Members Subject to Disclosure Requirement
 - 1. Members must disclose conflicts of interest if:
 - o they are asked to serve as proctors or reviewers;
 - o they are appointed to chair committees, including but not limited to hearing committees;
 - o they are elected to be a Medical Staff officer.

All applicable Medical Staff members shall file a conflict of interest report with the Medical Staff office. The President of the Medical Staff and Vice President of Medical Affairs (VPMA) shall review all reports. The Medical Staff Office shall maintain a copy of the conflict of interest disclosure report. The information is shared only with those who need the information. Failure to disclose a conflict of interest upon reasonable request will automatically disqualify the member from the position creating the conflict of interest.

- a. Disclosing Financial Information

Members' financial interests are unrelated to qualifying for and maintaining Medical Staff membership and privileges. However, financial interests could be an issue when the member serves as a peer reviewer, a proctor, in Medical Staff leadership and on committees or on the Governing Body. Those financial interests that may influence or appear to influence members in certain leadership or decision-making situations must be disclosed in those circumstances in which the financial interests are or could be involved, including:

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

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

1. Employment, partnership or other economic affiliation
2. Family relationship/Friendship
3. Enmity or serious hostility

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

- c. Procedure to be followed at meetings involving Medical Staff leaders when actual or potential conflicts of interest have been disclosed by a member and the potential conflict may impact the activities of the meeting:
 1. Whenever a body, such as a Medical Staff committee, is considering a transaction or arrangement with an organization or individual which could result in a conflict of interest for the affected member, the affected member must disclose a conflict of interest.
 2. If there is a conflict of interest, the chair shall direct the affected member to leave the meeting during discussion of the matter that gives rise to the potential conflict of interest. If directed to leave, the affected member may make a statement or answer questions on the matter before leaving.
 3. The affected member shall not vote on the matter giving rise to the potential conflict unless permitted to vote by the body.
 4. If a member of the Medical Staff may receive a financial gain in a transaction or arrangement which such member is in a position to evaluate and approve, the following should be observed in addition to the provisions described above:
 - o The body may appoint a non-interested person or committee to evaluate alternatives to the proposed transaction.
 - o The affected member will not be present for discussion or vote regarding the transaction.
- d. Minutes of meetings when a conflict of interest is present shall reflect the following:
 1. A list of members present, and voting or abstaining
 2. If a member disclosed a potential conflict of interest
 3. That the issue of a conflict of interest was discussed and whether the members determined a conflict of interest existed
 4. If alternatives were proposed
 5. Whether a final decision or recommended action was made
- e. Retention period
 1. Conflict of interest documents will be retained in the Medical Staff office for 7 years.

SECTION 5. RESIDENTS AND FELLOWS

Prerogatives available to Residents and Fellows will be handled according to the Medical Staff policies and procedures. Residents are not members of the Medical Staff. Fellows may apply for membership and privileges outside of their training programs.

SECTION 6. LEAVES OF ABSENCE

Leaves are only necessary if the member anticipates being unable to fulfill Medical Staff responsibilities for three months or more.

a. **Initiating Leave**

A member obtains a leave of absence by submitting a form approved by the MEC for that purpose, stating the reason for the leave and the period of the leave, which cannot exceed the member's present term of membership. No member can take more than one leave of absence during a two-year membership term unless approved by the MEC. Taking a leave under false pretense or other abuses of the leave of absence process, as determined by the MEC, is grounds for corrective action, including denial of renewal of membership, as a violation of these bylaws. However, requests for leave of absence to fulfill military service obligations or to obtain treatment for a medical or behavioral condition or disability shall not be denied or result in denial of renewal of membership if the applicant otherwise qualifies for membership and there are no other adverse recommendations affecting consideration of renewal of membership.

b. **Returning From Leave**

Six weeks prior to the date on which the leave of absence is scheduled to expire, the member may request reinstatement of privileges by submitting a written request to the Medical Staff office. The member must also submit a summary of relevant activities during the leave. The Medical Staff office forwards the request to the MEC. At its next regularly scheduled meeting, the MEC will consider the request and make a recommendation regarding reinstatement and privileges to the Governing Body which takes final action regarding all such requests. If the member is on a leave of absence when he/she is due for reappointment, the member will be requested to submit necessary reappointment paperwork as per the usual reappointment schedule. In this instance:

1. Correspondence will be mailed to the last known address unless otherwise indicated.
2. The member's reappointment application will be sent through the usual channels and the member may be granted conditional reappointment.
3. The reappointment shall remain conditional until the member satisfies the requirements for reinstatement.

Failure to request reinstatement in a timely manner is deemed a voluntary resignation from the Medical Staff as of the scheduled expiration date of the leave, or expiration of current Medical Staff appointment period unless the member has timely submitted an application for reappointment. A member who wishes to contest this result may seek review by the MEC. The request for review must be in writing by the affected member. Following review, the MEC's decision is final, and the member has no right to a Hearing and Appeal process under these

bylaws. A request for Medical Staff membership subsequently received from a member so terminated is treated as an application for initial membership.

SECTION 7. CONTRACT AND EMPLOYED MEMBERS

Members employed by or otherwise under a Medical Center contract, on an exclusive, part-time, panel or other basis, to provide clinical services to patients or to provide back-up call or other coverage must meet all qualifications and otherwise comply with the Medical Staff bylaws. They are subject to the same peer review, credentialing and hearing and appeal processes established in these bylaws. Contracting or employed members may qualify for election to Medical Staff leadership and appointment to committees but must disclose their contractual or employment relationship as a potential conflict of interest. Employed or contracted members shall be free to exercise their professional judgment in voting, speaking and advocating on any medical staff matter and shall not be deemed in breach of their employment or other agreements, nor otherwise be retaliated against by the Hospital, for doing so in good faith.

ARTICLE II CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE MEDICAL STAFF

The Medical Staff shall be organized into active, affiliate, associate and courtesy categories.

SECTION 2. THE ACTIVE MEDICAL STAFF

The active Medical Staff shall consist of physicians, dentists and podiatrists who regularly admit patients and/or provide services in the hospital, who are able to comply with department response times and otherwise provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the active Medical Staff including emergency department coverage and consultation assignment as determined by the medical staff emergency department plan which is approved by the MEC. Members of the active Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office, and to serve on Medical Staff committees.

SECTION 3. THE AFFILIATE MEDICAL STAFF

The affiliate Medical Staff shall consist of physicians, podiatrists and dentists who wish to be associated with Mercy Medical Center and its Medical Staff but have little or no active practice in the hospital. Members of the affiliate Medical Staff shall be appointed to a specific department of the Medical Staff, shall be eligible to vote, and shall be eligible to serve on Medical Staff committees. They shall be ineligible to hold office in this Medical Staff organization.

Affiliate Medical Staff members shall not have clinical privileges or provide orders on inpatients. Affiliate Medical Staff members wishing to refer a patient for inpatient care shall be responsible for arranging, at the time of admission, for the overall medical responsibility for the patient's care in the hospital to be assumed by a Medical Staff member of the appropriate specialty who holds full admitting privileges.

SECTION 4. THE ASSOCIATE MEDICAL STAFF

The associate Medical Staff shall consist of physicians, dentists and podiatrists who are being considered for advancement to membership as active or courtesy members of the Medical Staff. They shall be appointed to a specific department and may be appointed to serve on committees. They shall be ineligible to hold office in this Medical Staff organization. However, candidates for active staff status shall have voting privileges and shall accept emergency department coverage assignments.

All associate Medical Staff memberships shall be provisional for a period of one year. Associate membership renewal may not exceed an additional year, following which the failure to advance from associate Medical Staff membership shall be deemed a termination of Medical Staff membership. An associate Medical Staff member whose membership is so terminated shall have hearing rights accorded by these bylaws if the termination is an Adverse Action as defined in these bylaws.

Associate Medical Staff members shall be assigned to a department where their performance shall be evaluated by the chairperson of the department or the chairperson's representative in order to determine the eligibility of such associate staff members for continued Medical Staff membership and for exercising the clinical privileges provisionally granted to them.

SECTION 5. THE COURTESY MEDICAL STAFF

The courtesy Medical Staff shall consist of physicians, dentists and podiatrists qualified for Medical Staff membership but who only occasionally attend patients in the hospital. Courtesy Medical Staff membership is limited to those individuals who bring a unique skill to the community, or serve only occasionally as consultants in the hospital. Telemedicine members will be members of the courtesy Medical Staff. Courtesy Medical Staff members shall be appointed to a specific department. They shall be ineligible to vote or hold office in this Medical Staff organization and shall not be required to provide emergency department coverage.

ARTICLE III CREDENTIALING PROCEDURE

SECTION 1. MEMBERSHIP APPLICATION

- a. All Medical Staff membership applications shall be authenticated by the applicant, and shall be submitted on a form prescribed by the Governing Body and the MEC. The application shall provide detailed information concerning the applicant's professional qualifications as follows:
 1. Information substantiating qualifications established in these bylaws
 2. Agreement to present to the Medical Staff office a valid and current hospital picture identification or government-issued picture identification

3. The name of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate reference pertaining to the applicant's professional competence and ethical character
 4. Whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, or not renewed at any other hospital or institution
 5. Previously successful or pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration shall be reported to the hospital
 6. Previous conviction or charge of a felony or misdemeanor (other than misdemeanor traffic violations) shall be reported to the hospital
 7. National Practitioner Data Bank query
 8. Criminal Background Check
 9. Current Federal and State DEA certificates
 10. Current exclusion from Medicare or Medicaid or other federal healthcare programs.
 11. The applicant shall show proof of current malpractice liability insurance. The amount of minimum coverage per claim or per medical incident provided and maintained throughout the Medical Staff year must be at or above the level required by these bylaws. The applicant must report any final judgments or settlements made personally or on the applicant's behalf related to any professional liability action
 12. Current Iowa Medical License
- b. The applicant shall have the burden of producing adequate and accurate information for a proper evaluation of professional competence, character, ethics, current health status, and other qualifications and for resolving any doubt about such qualifications.
- c. The complete application shall be submitted to the Medical Staff office. After collecting and verifying the references and other materials deemed pertinent and consistent with the requirements of these bylaws, the application and all supporting materials shall be transmitted to the relevant department chair(s) for evaluation.
- d. By applying for Medical Staff membership, each applicant thereby signifies willingness to appear for interviews in regard to the application; authorizes the hospital to consult with members of Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his or her competence, character, and ethical qualifications, and current health status; consents to the hospital's inspection of all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence to carry out the clinical privileges requested; releases from any liability all representatives of the hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant's credentials; and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointments and clinical privileges, including otherwise privileged or confidential information.

- e. By applying for Medical Staff membership, each applicant agrees that any material misstatements, omissions or misrepresentations will constitute grounds to reject the application without rights of a hearing or appeal. If requested, the applicant is responsible for providing additional information to supplement his or her application or resolve questions arising from the application process that may be material prior to final action by the Governing Body. Each applicant also agrees that material misstatements, omissions or misrepresentations are grounds for corrective action, and could lead to rejection of an application or dismissal from the Medical Staff without rights to a hearing or appeal. A rejection of an application based upon a material misstatement, omission or misrepresentation by the applicant shall be disclosed to the applicant in writing.
- f. The application form shall include a statement that the applicant has received and agrees to abide by the bylaws, rules, and regulations of the Medical Staff and that the applicant agrees to be bound by the terms thereof, without regard to whether or not the applicant is granted membership and/or clinical privileges in all matters relating to consideration of the application.

SECTION 2. APPLICATION REVIEW PROCESS

- a. This Section 2 sets forth the application review process and sets forth time periods by which actions on the application are to be taken in the process. Within 60 days after receiving a Completed application for membership from the Medical Staff office, the Credentials Committee shall make a written report of its evaluation to the MEC. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, current health status, and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including a written appraisal from the chair of the clinical department in which privileges are sought, whether the applicant has established that he/she meets all of the necessary qualifications for the category of Medical Staff membership and the clinical privileges requested. At the discretion of the Credentials Committee, the applicant, in addition to the information submitted, may be requested to personally appear and be given an opportunity to be heard before the Credentials Committee or be interviewed by telephone by a committee member. Decisions on staff membership and privileges made by the Credentials Committee shall be by majority vote of all members of that committee. The chairperson of every department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for delineating the applicant's clinical privileges, and these recommendations shall be made a part of the report. Should the relevant department chairperson fail, absent a good-faith reason, to provide recommendations to the Credentials Committee within its sixty-day review period, the Credentials Committee shall nonetheless complete its report, and shall notify the MEC of the department chairperson's failure to fulfill his/her duties regarding the application. Together with its report, the Credentials Committee shall transmit the Completed application to the MEC along with a recommendation to grant, reject or defer the application for further consideration, and the reasons therefore.

- b. At its next regular meeting, which shall be held within forty-five (45) days of the receipt of the Completed application, or, at a special MEC meeting if the MEC's next regular meeting is more than forty-five (45) days from the date of receipt of the Completed application, the MEC will consider the report and recommendation of the Credentials Committee, and will forward its own recommendation for granting, rejecting or deferring the application for provisional membership status to the Governing Body. The MEC will recommend granting specific privileges and may recommend restrictions on privileges to include monitoring or proctoring.
- c. When the recommendation of the MEC is to defer the application for further consideration, it must be followed up within 30 days with a subsequent recommendation either for membership with specific clinical privileges or for rejection for Medical Staff membership.
- d. All recommendations of the MEC shall thereupon be promptly forwarded to the Governing Body for final action.
- e. A Completed application for membership or membership renewal can be expedited if it documents each of these criteria:
 - 1.No current or previously successful challenges to any professional licensure or registration;
 - 2.No involuntary termination of Medical Staff membership at the Hospital or at any other organization;
 - 3.No involuntary limitation, reduction, denial, or loss of clinical privileges at the Hospital or at any other organization;
 - 4.No excessive number or unusual pattern of professional liability actions resulting in final judgment against the applicant.

Applications meeting these criteria are reviewed by the relevant department chair(s); if approved by the relevant department chairs, the application is reviewed by the Chairperson of the Credentials Committee; if approved by the Chairperson of the Credentials Committee, the application is reviewed by the MEC or the President of the Medical Staff acting on behalf of the MEC between regularly scheduled meetings, in lieu of the application process described in these bylaws, and then forwarded to the Governing Body for final action. If any of these Medical Staff authorities makes any adverse recommendation, the application shall no longer be eligible for expedition, and shall revert to the regular application process. An expedited application may be acted upon by a committee of the Governing Body, if permitted by the hospital and Medical Staff bylaws.

- f. The Governing Body or its designated representatives are authorized to:
 - 1. Appoint the applicant to the staff with a delineation of privileges which may be exercised
 - 2. Reject the application for staff membership and/or privileges requested
 - 3. Defer final determination by referring the matter back to the MEC for further consideration. The reasons for referral shall be stated and a time limit established within which a subsequent recommendation to the Governing Body shall be made. The Governing Body shall consider such recommendation before making a final decision.

- g. All decisions to appoint shall include a delineation of the Clinical privileges which the applicant may exercise. In the event the decision of the Governing Body results in Adverse Action to the applicant, the hearing and appeals process established in these bylaws will apply.
- h. At its next regular meeting after all of the applicant's rights under these bylaws have been exhausted or waived, the Governing Body or in the case of an expedited application, its designated committee shall act in the matter. The decision of the Governing Body, or its designated committee, shall be conclusive, except that the Governing Body may defer final determination by referring the matter back to the MEC for further consideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Governing Body shall make a decision either to appoint the applicant to the Medical Staff provisionally or to reject the applicant for Medical Staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the member may exercise.
- i. When the Governing Body's decision is final, it shall send notice of such decision through the CEO to the Secretary of the Medical Staff, the President of the Medical Staff, and the relevant department chairperson(s), and by special notice to the applicant.

SECTION 3. MEMBERSHIP RENEWAL PROCESS

- a. Medical Staff members seeking membership renewal must be evaluated at least every 2 years.
- b. Each member scheduled for membership renewal must provide information, as requested, pertinent to his/her professional competence and professional conduct and shall include information relevant to the privileges requested consistent with the these bylaws. The member agrees to provide information that is accurate and truthful. Furthermore, the member agrees that he or she has an ongoing obligation during each reappointment period to provide timely information that may be material to the member's professional competence, personal conduct, and other qualifications for Medical Staff membership including:
 - 1. Quality Data available
 - 2. Current Iowa Medical License
 - 3. Current Federal and State DEA certificates
 - 4. Previous conviction or charge of a felony or misdemeanor (other than misdemeanor traffic violations) shall be reported to the hospital
 - 5. Current exclusion from Medicare or Medicaid or other federal healthcare programs
 - 6. Office of Inspector General sanctions
 - 7. All members must show proof of current malpractice liability insurance as described in these bylaws to be eligible for membership renewal
 - 8. National Practitioner Data Bank query

- c. After review and recommendation by the relevant department chair(s), the Credentials Committee shall review all pertinent information available on each member scheduled for periodic appraisal for the purpose of determining its recommendations for Medical Staff membership renewal and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the MEC. When membership termination or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented. At the discretion of the Credentials Committee the member may be allowed to personally appear and be given an opportunity to be heard before the committee.
- d. Each recommendation concerning Medical Staff membership renewal and the clinical privileges to be granted upon membership renewal shall be based upon such member's professional competence and clinical judgment in the treatment of patients; current health status relative to the member's ability to perform appropriately his or her Medical Staff and professional duties; participation in staff affairs; compliance with the Medical Staff bylaws, rules and regulations, and policies; appropriate use of the hospital's facilities and services for his or her patients; relations with other practitioners; and compliance with the standards of professional conduct as written in these bylaws.
- e. The procedure provided in these bylaws relating to recommendation on applications for initial membership shall be followed for membership renewal.

SECTION 4. CREDENTIALS FILES

- a. Should the hospital be closed, the Governing Body will arrange for the credentials files and other Medical Staff records to be placed with an appropriate custodian for a minimum of two years after closure, during which time the records will be maintained as confidential but the members will be permitted access. At least thirty days in advance of closure of the hospital, the CEO notifies all Medical Staff members of the arrangements for storage and appropriate access.
- b. Access to Medical Staff credentials files is limited to those identified here, under the circumstances identified here.
 - 1. Only those Medical Staff leaders and administrative personnel carrying out peer review and other Medical Staff operations have access to credentials files, and only as needed to fulfill their legitimate duties.
- c. Medical Staff members are granted access to their own credential's files upon written request, with the exception of letters of reference, but only for review in the Medical Staff office, at a time convenient to the member and the Medical Staff office supervisor or designee, in whose presence the member's review will take place. The member may receive a copy of only those documents provided by or addressed personally to the member. The member may request in writing that the MEC either correct or amend information in the member's credentials file. Information supporting the request should be included. The member is notified promptly, in writing, of the decision of the MEC.

In the event of an action or proposed action against a member, applicant, or holder of clinical privileges, access to that member's credentials file is governed by the hearing procedures established in the Medical Staff bylaws.

- d. No patient survey or customer satisfaction information is placed in credentials files or used in credentialing unless it has been reviewed by the appropriate committee or department and determined to serve to document the member's qualifications for Medical Staff membership and/or clinical privileges.
- e. Any person may provide information to the Medical Staff about the conduct, performance or competence of its members or applicants. When information is provided, the relevant department chair and/or President of the Medical Staff shall review the information and decide:
 - 1. That the information is unreliable and should not be placed in the file;
 - 2. To notify the member of any information by a written summary and offer him or her the opportunity to respond before it is placed into his or her file; or
 - 3. To place the information in the file at the discretion of the relevant department chair and/or President of the Medical Staff, along with a notation if a request has been made to the MEC to initiate corrective action against the member as outlined in these bylaws.

ARTICLE IV CLINICAL PRIVILEGES

SECTION 1. GRANTING AND REVIEW OF CLINICAL PRIVILEGES

Applicants are not required to apply for or hold all those privileges for which they are qualified. Rather, each member or practitioner chooses what privileges he or she requests and applies for. All privileges initially granted to new members, held as temporary privileges or granted as additional privileges to a current member, are subject to focused review as described in these bylaws.

- a. Every practitioner or member practicing at this hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted pursuant to these bylaws. Clinical privileges granted through the credentialing process shall be reassessed periodically, at intervals not to exceed two years.
- b. All initial applications for Medical Staff membership must contain a request for the specific clinical privileges the applicant desires. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including a peer review recommendation appraisal by the relevant clinical department chair(s) in which the applicant most recently had clinical privileges or received residency/fellowship training in which such privileges are sought. The applicant shall have the burden of establishing his or her qualifications and competency for the clinical privileges requested.

- c. Clinical privileges are periodically reviewed, and may be granted unchanged, or granted with conditions based upon the member's training, experience and demonstrated competence substantiated by a peer recommendation.
- d. Within 30 days, the chairperson of the clinical department in which the applicant is requesting specific privileges or revision of existing privileges will review all such requests and make a recommendation to the Credentials Committee chairperson based upon demonstrated ability and competence consistent with relevant departmental standards. All departmental recommendations shall indicate whether the necessary resources are currently available to support the privileges requested and recommended to be granted. Should the department chairperson fail, absent a good-faith reason, to provide a recommendation to the Credentials Committee within its thirty-day review period, the Credentials Committee shall nonetheless complete its report, and shall notify the MEC of the department chairperson's failure to fulfill his/her duties regarding the application.
- e. Where specific privilege(s) are performed by members of more than one clinical department, the affected departments shall collaborate in developing acceptable criteria which ensure quality of care by all members and practitioners.
- f. Privileges granted to dentists, including oral and maxillofacial surgeons, shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of dental surgical procedures permitted under these bylaws shall be delineated and granted in the same manner as all other surgical privileges. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the history and physical and the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.
- g. Privileges granted to podiatrists shall be based upon their training, experience, and demonstrated competence and judgment. The scope and extent of podiatric surgical procedures permitted under these bylaws shall be delineated and granted in the same manner as for all other surgical privileges. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the medical history and physical and the care of any medical problem that may be present or may arise during hospitalization. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and physical examination and all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his/her license and as consistent with the Medical Staff regulations.

SECTION 2. CATEGORIES OF TEMPORARY PRIVILEGES

- a. Temporary privileges upon receipt of an application to the Medical Staff-
Upon receipt of an application for Medical Staff membership from an appropriately licensed applicant, the CEO or authorized designee may with the written concurrence of the relevant department chair, and the President of the Medical Staff or authorized

designees, grant temporary admitting and clinical privileges requested by the applicant after verification of the following:

1. Current licensure
2. Relevant training or experience
3. Current competence
4. Ability to perform the clinical privileges requested
5. Other membership criteria required by these Medical Staff bylaws
6. Query and evaluation of National Practitioner Data Bank information
7. Absence of current or previously successful challenge to licensure or registration
8. Absence of involuntary termination of Medical Staff membership at any hospital or other healthcare institution for professional or personal conduct
9. Absence of any involuntary limitation, reduction, denial or loss of clinical privileges

If granted temporary privileges, the applicant shall act under the supervision of the relevant department chair to which they are assigned. The temporary privileges shall remain in effect for a limited period of time not to exceed 120 days. Temporary privileges automatically terminate if the applicant's initial membership application is withdrawn.

b. Temporary privileges granted to fulfill a special clinical need-

Temporary clinical privileges may be granted by the CEO or authorized designee, with the written concurrence of the relevant department chair, and President of the Medical Staff or authorized designees, to a physician, dentist or podiatrist who is not an applicant for membership in order to fill an important patient care need such as providing treatment needed that no Medical Staff member is able or available to, covering for an absent Medical Staff member, or otherwise. Temporary privileges will be granted after current licensure and current competence are verified.

c. Disaster Privileges

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

1. Current valid medical license with primary source verification
2. A current Hospital picture identification that clearly identifies professional designation
3. Primary source verification of the license
4. Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups
5. Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances

6. Identification by current hospital staff or Medical Staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster

Verification of the credentials of a non-member of the Medical Staff functioning under the emergency management plan will begin as soon as the emergency situation is under control, not to exceed 72 hours. The Medical Staff shall oversee the professional practice of the volunteer according to departmental rules and regulations, as established by the clinical department in which privileges are held and approved by the MEC. The individuals listed above who may grant, may also withdraw disaster privileges at any time. Refusal or withdrawal of any disaster privileges does not give the right to the hearing and appeals process, unless the refusal or withdrawal results in a report to any state or national agency. Disaster privileges terminate automatically when the disaster is over as determined under the terms of the hospital emergency management plan.

d. Locum tenens

The CEO or authorized designee may permit a physician serving as a locum tenens for a named member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed 60 days, providing all credentials have first been verified by the Medical Staff office and approved by the relevant departmental chair, and the President of the Medical Staff. The application shall require detailed information concerning the applicant's professional qualifications as follows:

1. Current Iowa Medical License
2. Proof of current malpractice liability insurance. The amount of minimum coverage per claim or per medical incident provided and maintained throughout the Medical Staff year must be at or above the level recommended by the MEC and the Governing Body. The applicant must report any final judgments or settlements made personally or on the applicant's behalf related to any professional liability action.
3. Current Federal and State DEA certificates
4. Absence of current or past exclusion from Medicare or Medicaid or other federally funded programs
5. Absence of any prior Office of Inspector General sanctions
6. Criminal Background Check
7. Recent hospital affiliation (2 years)
8. National Practitioner Data Bank query

e. Special requirements for supervision and reporting may be imposed by the departmental chairperson on anyone granted temporary privileges. Temporary privileges may be immediately terminated by the CEO with the written concurrence of the relevant department chair, and President of the Medical Staff upon notice of any failure by the individual to comply with such special conditions.

f. All persons requesting or receiving temporary privileges are bound by the Bylaws and Rules and Regulations of the Medical Staff. If temporary privileges are terminated for reasons meeting the definition of Adverse Action under these bylaws, hearing and appeal rights apply.

SECTION 3. ADMITTING PRIVILEGES

Admitting privileges must be specifically requested and are granted only to qualified requestors meeting the clinical criteria established by the relevant clinical department and approved by the MEC. This provision does not prohibit exclusive contracts for clinical services, however, admitting privileges are not exclusive to hospital employees, members with hospital contracts, or to any single specialty.

SECTION 4. HISTORY AND PHYSICAL PRIVILEGES

- a. Only those granted privileges to do so may conduct history and physicals or update histories and physicals. History and physical privileges must be carried out consistent with the requirement of these bylaws.
- b. History and physical privilege must be exercised prior to surgery or a procedure requiring anesthesia services so that each patient is provided a history and physical examination within 30 days before admission (or registration, in an outpatient procedure) or within 24 hours after admission.
- c. When the medical history and physical examination are completed within 30 days before admission, an updated examination of the patient, including any changes in the patient's condition must be completed and documented within 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services.

Those who are eligible or entitled to History and Physical privileges include:

- a. Physicians – Physician Medical Staff members or physicians granted privileges to conduct and update histories and physicals.
- b. Podiatrists – Podiatrists co-admit with a Medical Staff member with admitting privileges who is responsible for the podiatric patient's inpatient care and medical problem or condition that may exist at the time of admission (including performing admission history and physicals), or problems that may arise during hospitalization that exceed the Podiatrists privileges or scope of licensure and practice.
- c. Dentists/Oral and Maxillofacial Surgeons – Dentists/Oral and Maxillofacial Surgeons co-admit with a Medical Staff member with admitting privileges who is responsible for the dental patient's inpatient care and medical problem or condition that may exist at the time of admission (including performing admission history and physicals), or problems that may arise during hospitalization that exceed the Dentists/Oral and Maxillofacial Surgeons privileges or scope of licensure and practice.

SECTION 5. TELEMEDICINE PRIVILEGES

- a. Telemedicine is the provision of clinical services to patients by Members from a distance via electronic communications. It encompasses the overall delivery of healthcare to the

patient through the practice of patient assessment, diagnosis, treatment, consultation, transfer and interpretation of medical data and patient education all via a telemedicine link (for example, audio, video, and data telecommunications as may be utilized by distant-site Members). The Governing Body shall have final approval of the clinical services to be provided through telemedicine by a Member after considering the recommendations of the MEC.

- b. For purposes of these bylaws, the definition of an “Originating Site” is one where the patient is located at the time the service is provided. The definition of “Distant Site” is one where the Member providing the professional service is located. This may include a Distant Site hospital or Distant Site telemedicine entity as defined and set forth in the CMS Conditions of Participation, TJC Accreditation Standards and any other applicable accreditation standards or laws governing telemedicine privileges, which may change from time to time.
- c. In processing a request for Telemedicine Privileges at the Hospital, the MEC may rely on the credentialing and privileging decisions from the Distant Site to make its own credentialing and privileging recommendation to the Governing Body if the Hospital has a written agreement with the Distant Site which complies with CMS and TJC Standards, in effect from time to time. The Governing Body shall then consider the MEC’s credentialing and privileging recommendation for each Member or applicant requesting Telemedicine Privileges in making a final credentialing and privileging decision for the Hospital.
- d. All requests for telemedicine services will be evaluated by the Medical Staff at the Hospital to make sure that they can be safely provided on an ongoing basis. This evaluation will include discussion of which clinical services are appropriately delivered through telemedicine and are consistent with commonly accepted quality standards. The medical staff at the Distant Site will be involved in evaluating the performance of those services as part of privileging and as part of the reappraisal conducted at the time of reappointment or renewal or revision of Telemedicine Privileges at the Hospital.

SECTION 6. NEW PRIVILEGES

New privileges are approved by the Governing Body upon receipt of a recommendation by the MEC based upon recommendation of the Credentials Committee, and by the relevant clinical department which must first consider whether the facility has the resources necessary to support these activities. Members may submit a written request for these privileges to the Medical Staff office.

SECTION 7. RELINQUISHING PRIVILEGES

A Medical Staff member who wishes to relinquish or limit particular clinical privileges sends written notice to the MEC, appropriate department chair(s), and the Medical Staff office identifying the particular clinical privileges to be relinquished or reduced. The request becomes effective 30 days after receipt by the Medical Staff office unless a later date is specified in the

notice. A request to relinquish or limit clinical privileges before 30 days must be approved by the appropriate clinical department chair(s), and the President of the Medical Staff.

SECTION 8. PERFORMING EMERGENCY CARE

In the case of emergency, any physician, dentist or podiatrist member of the Medical Staff with clinical privileges, to the degree permitted by his or her license and regardless of service or staff status or lack thereof, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital as necessary, including obtaining any consultation or assistance required. When the affected patient is stabilized, they shall be assigned to an appropriate member of the Medical Staff with appropriate clinical privileges. For the purpose of this section, an “emergency” is defined as a clinical condition in which any delay in providing immediate medical care places the patient in immediate danger with risk of permanent harm or death.

SECTION 9. RESIDENTS AND FELLOWS

Prerogatives available to Residents and Fellows will be handled according to the Supervision of Graduate Medical Education policy. Residents are not members of the Medical Staff. Fellows may apply for membership and privileges outside of their training programs.

ARTICLE V PROFESSIONAL PRACTICE EVALUATION

The personal and professional conduct of all members of the Medical Staff and all non-members granted privileges under these bylaws is subject to review. For members of the Medical Staff, these bylaws are the exclusive means for professional review.

The results of ongoing and focused professional review are factors affecting the decisions regarding membership and privileges. Such review may yield recommendations for changes in the systems operating in the department, Medical Staff, or hospital to improve patient care and safety. The MEC approves the type of data to collect for use in any professional practice evaluation, and the criteria to be used for all practice review of a member or practitioner’s services provided, or whenever quality patient care issues are identified. The MEC is responsible for consistent use of criteria in peer review.

Complaints or other concerns raised about a member of the Medical Staff or practitioner are reviewed to determine if the complaint or concern is baseless, focused review or corrective action is warranted, or to refer the subject to the Wellness Committee of the Medical Staff.

SECTION 1. FOCUSED REVIEW OF INITIAL PRIVILEGES

All privileges initially granted to new members, held as temporary privileges, or granted as additional privileges to a current member, are subject to focused review as described in these bylaws. Subsequent to focused review, all members undergo ongoing practice evaluation, the standards of which are established by the Medical Staff and in these bylaws.

- a. The relevant department chair(s) may assign a proctor to conduct the focused review. Where proctoring is not required, focused review may include chart review, monitoring clinical practice patterns, simulation, external peer review and discussion with other individuals involved in the care of the member's patients. The department chair is responsible for monitoring the focused review and communicating with the member or practitioner.
- b. At the end of the evaluation period, or sooner if deviations from professional practice or conduct standards occur, the department chair assesses the available information as part of this peer review process.
- c. Where the member or practitioner demonstrates acceptable performance in the requested privileges, the relevant department chair will forward his or her recommendation to the Credentials Committee, who will then forward its recommendation to the MEC.
- d. Where the focused review identifies individual, department or system-wide deficiencies, further performance monitoring, corrective action, or other measures may be recommended by the department chair to the Credentials Committee and then forwarded to the MEC.
- e. At any time during the focused review period a member of the Medical Staff may voluntarily withdraw the request for additional privileges without penalty or reporting obligation.

SECTION 2. FOCUSED PROFESSIONAL PRACTICE REVIEW

If the focused review process is unrelated to granting of new or expanded privileges, but is undertaken to evaluate concerns regarding professional practice or conduct, it may produce adverse results impacting membership status or involuntary change in privileges. In this event, the focused review may implicate further actions under these bylaws.

All focused professional practice review shall include consideration of pre-event occurrences and systemic factors. The subject of the review is included early in the review process and as appropriate throughout, to promote the sharing of information. All recommendations for corrective action are supported by findings and reported to the affected member or practitioner and the MEC, specifying the standards at issue, deviations identified, steps that should be taken, and recommendations for future compliance and remediation. If appropriate under department standards, performance monitoring, corrective action or other measures are implemented or recommended.

SECTION 3. ONGOING PROFESSIONAL PRACTICE REVIEW

Ongoing review of all members and practitioners takes place in each department and section as the department and section determines and as is consistent with these Medical Staff bylaws. Employed and contracted members will be treated under the same process.

SECTION 4. EXTERNAL REVIEW OF PROFESSIONAL PRACTICE

External peer review may take place as part of application processing, focused review, ongoing professional practice review, Investigation, or under the following circumstances, identified by the relevant clinical department(s) or the MEC:

- a. Vague or conflicting recommendations from committee or departmental review(s) where conclusions from this review could adversely affect an individual's membership or privileges.
- b. Lack of internal expertise, in that no member of the Medical Staff has adequate expertise in the clinical procedure or area under review.
- c. When the Medical Staff or the Governing Body needs an expert witness for a fair hearing, for evaluation of a credentials file or for assistance in developing a benchmark for quality monitoring.
- d. To promote impartiality in peer review.

A practitioner or member subject to review or Investigation can request the Hospital or Medical Staff to obtain external peer review, and shall have an opportunity to reasonably object to the selection of a particular external peer reviewer. However, the decision whether to use an external peer reviewer, and the selection of a particular external peer reviewer, shall be that of the Hospital or Medical Staff, depending on which body initiated the review or Investigation.

SECTION 5. PROFESSIONAL PRACTICE INVESTIGATION PROCESS

Whenever the professional conduct of any member or practitioner with clinical privileges is considered to be (i) detrimental to patient safety; (ii) Lower than the acceptable professional standards of the Medical Staff; or (iii) contrary to the Medical Staff bylaws and/or rules and regulations, a request for review of professional practice may be made.

- a. A request for review of professional practice of any Medical Staff member may be made in writing to the President of the Medical Staff, relevant department chair, or the VPMA. Upon receipt of such request, the affected department chair and VPMA will jointly review the request to determine if the complaint is credible and requires further evaluation.
- b. The VPMA will acknowledge in writing receipt of the complaint to the person generating the complaint.
- c. If the complaint is found to raise legitimate concerns as to the professional conduct or competency of the Medical Staff member or practitioner, it will be referred to the Peer Review Committee for review and Investigation. However, if the VPMA and affected department chair determine that an external review is appropriate, the VPMA and affected department chair shall arrange for an external peer review instead of utilizing a Peer Review Committee.
- d. The Peer Review Committee, subject to the conflict of interest rules in these bylaws, shall consist of at least three (3) members of the Medical Staff and should consist of a representation from a variety of specialties. Other members of the Medical Staff may be called to participate in a consultative role.

- e. The types of cases reviewed by the Peer Review Committee may include, but are not limited to:
 - 1. Surgical and/or procedure complications
 - 2. Improper use of medications/blood products
 - 3. Medical and/or surgical incident reports requiring additional input
 - 4. Significant deviations from professional practice norms monitored by quality improvement indicators as identified by department chairs
 - 5. Cases referred by the MEC.

- f. Within thirty (30) days of receiving a written request for formal review, the Peer Review Committee will:
 - 1. Formally conduct its review – the affected member or practitioner is encouraged early in the review to assist the committee in its deliberations and promote a mutual sharing of information.
 - 2. Complete its review within 30 days. However, the committee may extend the review process if needed, but the extension should not exceed an additional 30 days unless there are extraordinary circumstances warranting a longer extension.
 - a. The Peer Review Committee will determine if:
 - i. A significant quality of care issue exists
 - ii. A quality of care concern is present, but creates little or no risk of patient harm
 - iii. A quality of care concern has contributed to, or creates a material risk of patient harm.
 - b. Where the Peer Review Committee identifies a specific quality of care issue, it may recommend one or more of the following:
 - i. Additional training or proctoring
 - ii. Requirement for consultation
 - iii. Formal period of review (FPPE)
 - iv. Formal letter of reprimand
 - v. Letter of education
 - vi. Suspension, reduction, or termination of clinical privilege(s) or membership
 - vii. Any other such action as determined appropriate

- g. Within 15 days of completing its review, submit a written report of its findings and recommendations to the MEC.

- h. The MEC shall review the matter within thirty (30) days following the receipt of the report, or at its next scheduled meeting following receipt of the report. However, the MEC may extend the review process if needed, but the extension should not exceed an additional 30 days unless there are extraordinary circumstances warranting a longer extension. In reviewing the matter, and prior to taking action, the MEC may, at its discretion, permit the affected member or practitioner to appear before the MEC. Such appearance is not mandatory, does not constitute a hearing, and shall be preliminary in nature. None of the procedural rules provided in these bylaws with respect to hearing shall apply.

- i. Upon completion of its review, the MEC will:
 - 1. Accept, modify or reject the recommendation of the Peer Review Committee

2. Within 5 days after concluding its review, notify the CEO and the affected member or practitioner of all findings and recommendations made by the MEC, and whether any of the recommendations are for Adverse Action giving rise to a member's right to request a hearing.

ARTICLE VI PERSONAL CONDUCT

SECTION 1. APPROPRIATE PERSONAL CONDUCT

The following kinds of conduct by members and practitioners are not restricted by these bylaws:

- a. Advocating for patients.
- b. Input that is meant to improve care.
- c. Engaging in legitimate professional business enterprises.

SECTION 2. ACTIONABLE PERSONAL CONDUCT

Deviations from patient care standards and violations of Medical Staff bylaws, rules and regulations are addressed through the Peer Review and Corrective Action provisions of these bylaws. An individual's conduct, apart from his or her interaction with his or her patients, can be subject to corrective action if it undermines the Medical Staff culture of safety to promote quality patient care. Conduct that undermines the culture of safety includes:

- a. Harassment on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex or sexual orientation.
- b. Verbal, written, visual or physical abuse, directed against another Medical Staff member, house staff, hospital employee, contractor or volunteer, or patient.

Such conduct by members and practitioners is actionable under these bylaws.

SECTION 3. PERSONAL CONDUCT INVESTIGATION PROCESS

Members of the Hospital staff are encouraged to directly discuss with practitioners or members of the Medical Staff, when appropriate, issues of personal conduct that fall below standards established by the Medical Staff.

- a. Complaints or reports about the conduct of administrative personnel, nurses, and other non-Medical Staff health professionals, shall be made to the office of Human Resources.
- b. Where there is a reasonable concern that a practitioner's or member's conduct is below the standards set forth in these bylaws, a written report should be submitted to the VPMA, and shall include the following information:
 1. Name of practitioner or Medical Staff member;
 2. Date and time of the conduct in question;
 3. Actions affecting a specific patient;
 4. Contributing circumstances that may have precipitated the incident;

5. Objective description of the conduct in question;
 6. Names of others who witnessed the behavior;
 7. Adverse clinical consequences, or impact on patient care, hospital staff, or operations;
 8. Actions taken by staff or other practitioners or members of the Medical Staff in response to the situation, to include the date, time, place, and actions undertaken; and
 9. Name and signature of the individual reporting the behavior.
- c. The VPMA, or designee, will investigate the report, in consultation with the relevant department chair and Medical Staff president as necessary. The inquiry may include interviews with individuals reporting, or named in the report, and review all information deemed appropriate to the inquiry.
- d. The VPMA, after inquiry, may determine that the report is not founded within the context of this policy. The VPMA may dismiss the report on these grounds and will notify the individual who initiated the report of this decision.
- e. Informal Action
1. Single Incident
 - If the report reflects a single, isolated confirmed incident of conduct not meeting appropriate standards under these bylaws, the VPMA or designee will discuss the situation with the member or practitioner and/or may decide that the single incident is so significant that it warrants further action.
 - Discussions during an initial intervention are meant to be collegial and helpful to the member or practitioner and the Hospital.
 - The VPMA or designee will provide the member or practitioner with a copy of the Medical Staff bylaws as they pertain to the standards of personal conduct, and inform the member or practitioner that the Governing Body requires compliance.
 2. Significant Single Incident; Repeated Pattern of Departure from Personal Conduct Standards. For a single confirmed incident which the VPMA determines is so significant that it warrants further action, or for repeated pattern of substandard conduct, the VPMA and the President of the Medical Staff or designee(s) will proceed as follows:
 - Consult with the relevant department chair
 - Meet with the member or practitioner to provide him/her the opportunity to explain the conduct or activities in question, and emphasize to the member or practitioner that they must conform their personal conduct to meet the standards mandated by the Medical Staff bylaws. Any failure to meet these standards is not acceptable, and can be the basis for formal corrective action, and potential loss of Medical Staff membership or clinical privileges, either of which may require formal reporting to the NPDB and the Iowa Board of Medicine.
 - The MEC and CEO will be notified of the recurring conduct falling below established standards
 - All meetings shall be documented in writing in the member or practitioner's file
 - A follow-up letter will be sent to the member or practitioner stating the problem and notifying the member or practitioner that he or she is required to conduct themselves professionally and cooperatively.

- The affected Medical Staff member or practitioner may, at his or her discretion, reply in writing to the VPMA to respond to issues listed in the follow-up letter. This response will remain a part of the member or practitioner's record.
- The VPMA or the president of the Medical Staff may request that the member or practitioner's conduct be reviewed by the MEC.
- The VPMA or the President of the Medical Staff may, at any time, initiate formal corrective action in accord with the Medical Staff Bylaws and applicable policies.
- Summary suspension, as provided in the Medical Staff Bylaws, may be appropriate if the affected Medical Staff member or practitioner represents an immediate risk of harm to patients or others in the hospital.

f. Formal Action

1. Any officer of the Medical Staff, chairperson of a clinical department, chairperson of any standing committee of the Medical Staff, the CEO or designee, or the Governing Body in accord with these Medical Staff bylaws may, upon presenting a reasonable basis for action, request an invitation for corrective action at any time.
2. The action of the MEC upon receiving a request for corrective action may be one or more of the following, or other action as appropriate:
 - Determine that no action is warranted
 - Issue a warning, a letter of admonition, or a reprimand
 - Recommend terms of probation or a requirement for consultation
 - Recommend a reduction, suspension, or revocation of clinical privileges
 - Recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained
 - Recommend that the member's Medical Staff membership be suspended or revoked
 - Referral to the Medical Staff Wellness Committee

- g. Medical Staff members and practitioners are entitled to hearing and appeals rights as described in these bylaws if Adverse Action is recommended.

SECTION 4. ABUSE OF PROCESS

Retaliation against complainants or against those implementing this process, failure or refusal to cooperate with this process, even if the underlying accusation is found to be untrue, and abuse of the complaint process by members or practitioners to harass other members or practitioners are subject to corrective action under these bylaws. Abuse of the complaint process by non-Member Medical Center employees, board members or contractors is subject to discipline under Medical Center administrative policies.

ARTICLE VII CORRECTIVE ACTION

SECTION 1. AUTOMATIC ACTION LIMITING OR REVOKING PRIVILEGES

- a. A temporary suspension in the form of withdrawal of a member's or practitioner's privileges, effective until the delinquency is corrected, shall be imposed automatically for:

1. License - If a member's or practitioner's license to practice his or her profession in the State of Iowa is revoked, suspended, or the licensing agency imposes terms of probation or limitation of practice on the member or practitioner, his or her privileges shall immediately and automatically be suspended or limited from practicing in the Hospital, coincidental with the action taken by the state licensing board.
 2. Federal Drug Enforcement Administration (DEA) Number; State Controlled Substances Registration (CSR) - If a member's or practitioner's DEA or CSR number is revoked or suspended or voluntarily relinquished, he or she shall immediately and automatically be divested of his or her right to prescribe medications permitted by such number.
 3. Failure to Satisfy Special Appearance Requirement - A member or practitioner who fails to appear following a Special Appearance notice shall be subject to immediate and automatic suspension from exercising all or such clinical privileges at issue.
 4. Filing of Charges; Conviction of a Felony - After conviction of a felony or in certain cases after the filing of charges against a member or practitioner in any court of the United States, either federal or state, which in the judgment of the MEC or Governing Body is deemed to be detrimental to the Hospital or patient care, the member's membership and/or a member or practitioner's privileges are automatically suspended.
 5. Loss of Insurance - A member or practitioner who loses or fails to maintain malpractice insurance, in accordance with the requirements established under these bylaws, shall have his or her privileges immediately suspended and a special notice shall be issued to the member or practitioner stating that failure to acquire such insurance coverage within sixty (60) days shall constitute an immediate voluntary resignation from the staff.
 6. Exclusion from government payment programs - A member or practitioner who is suspended from government payment programs shall have his or her privileges automatically suspended. A member or practitioner who is excluded from participation in governmental health care programs shall have his or her Medical Staff membership and all Clinical Privileges immediately terminate as of the date of such exclusion without rights to a hearing or appeal.
 7. Delinquent medical records. A member or practitioner's clinical privileges may be suspended upon notice of delinquent medical records, consistent with the Medical Staff rules and regulations.
- b. Procedural Rights - Any member or practitioner whose privileges have been automatically suspended pursuant to this section may, within 10 days, submit a written request for a formal review of their suspension.
1. For such review, the affected member or practitioner must meet with the MEC, or a review panel appointed by the MEC, within 14 days to present evidence to establish that the automatic suspension was imposed in error.
 2. If the review panel concurs that the automatic suspension was imposed in error, the automatic suspension shall be immediately terminated.
 3. If the condition causing automatic suspension no longer exists, the President of the Medical Staff or designee shall terminate the automatic suspension upon review of

documentation that establishes that the reason for automatic suspension no longer exists.

4. If no review is requested, or if the review panel does not terminate the automatic suspension, the MEC shall, at its next scheduled meeting, act on the automatic suspension. The MEC may take or recommend such further corrective action as appropriate, including a recommendation to terminate membership and/or privileges due to ineligibility, or may continue the automatic suspension until the member or practitioner remedies the basis for the automatic suspension. If an automatic suspension continues for more than six consecutive months, the member shall be deemed to have voluntarily resigned Medical Staff membership and a member or practitioner shall be deemed to have voluntarily resigned his or her affected privileges.
- c. Immediately upon the imposition of automatic suspension, the President of the Medical Staff or the chairperson of the clinical department(s) in which the suspended member or practitioner has privileges shall arrange medical coverage for on-call obligations of the member or practitioner and arrange medical coverage for the hospitalized patients of the suspended member or practitioner at the time of such suspension. The wishes of the hospitalized patients shall be considered in the selection of the covering practitioner.

SECTION 2. SUMMARY SUSPENSION

- a. The President of the Medical Staff, or designee, and the CEO, or designee, shall together have the authority, whenever failure to take action may result in imminent danger to the health or safety of a patient, member, hospital employee or any individual, to summarily suspend the Medical Staff membership and/or all or any portion of the clinical privileges of a member or practitioner, and such summary suspension shall become effective immediately upon imposition.
- b. If either the President of the Medical Staff or CEO (or designee acting in the place of the President or CEO), disagree that summary suspension is warranted, the matter shall be referred to the Joint Conference Committee, which shall meet within 48 hours, and may summarily suspend by a majority vote if it determines that failure to take action may result in imminent danger to the health or safety of a patient, member, hospital employee or any individual. If no summary suspension is imposed, the matter shall be immediately referred to the peer review committee for review, and action as warranted.
- c. Immediately upon the imposition of summary suspension, the President of the Medical Staff or the chairperson of a clinical department(s) in which the suspended member or practitioner has privileges shall arrange medical coverage for on-call obligations of the member or practitioner and shall arrange medical coverage for the hospitalized patients of the suspended member or practitioner at the time of such suspension. The wishes of the patients shall be considered in the selection of the covering member or practitioner for the hospitalized patients.
- d. As soon as reasonably possible but no later than 14 days after the imposition of the suspension, or earlier if an accelerated review is requested in writing by the suspended staff

member or practitioner, the MEC shall be convened to review and consider the appropriateness of action taken. The MEC may terminate the summary suspension, and as warranted shall recommend to the Governing Body modification or continuation, of the terms of the suspension, or other corrective action.

- e. Unless the MEC immediately terminates the suspension and recommends no further corrective action, a member shall be entitled to the hearing and appeals procedural rights as provided in these bylaws, in which case, the terms of the suspension as sustained by the MEC shall remain in effect pending a final decision by the Governing Body.

ARTICLE VIII HEARINGS AND APPEALS

As used in this Article, “member” includes members of the Medical Staff, as well as applicants for Medical Staff membership and physicians, podiatrists and dentists who are temporary privileges holders. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article. No action will be final or reported to any governmental agency unless and until the member first has exercised or waived hearing rights under these bylaws or as otherwise required by law.

SECTION 1. GROUNDS FOR HEARINGS

Members are entitled to a hearing and appellate review upon the recommendation of an Adverse Action. No Member shall be entitled to a hearing as a result of any action recommended or taken that does not meet the definition of Adverse Action.

SECTION 2. NOTICE OF ACTION

The President of the Medical Staff or the President of the Board (depending upon which body recommended the proposed Adverse Action) shall notify the member by special notice of the proposed Adverse Action including the acts/omissions for which the member was reviewed, the findings of the MEC or the Board (depending upon which body recommended the proposed Adverse Action), and the reasons for its recommendation. The notice shall state that the Member has a right to a hearing pursuant to this Article VIII, and shall provide a summary of the hearing rights granted under these bylaws or attach a copy of this Article VIII. The letter will inform the member that he or she has the right to request a hearing on the proposed Adverse Action by providing the Hospital's CEO a written request within 30 days of the date of the notice of action. The written notice shall state that, if adopted, the action will be reported to the Iowa Board of Medicine and the NPDB as required by state and federal law.

SECTION 3. WAIVER OF HEARING AND APPEAL RIGHTS

If the member fails to request a hearing in accordance with these bylaws, such failure shall be deemed an irrevocable waiver of the right to such hearing and any appellate review. Waiver of hearing and appeals rights is deemed an acceptance of the recommendation or actions of the MEC or the Board (depending upon which body recommended the proposed Adverse Action). In such case, the matter shall be reviewed by the Governing Body for final action, in which case, the Governing Body shall consider the recommendation for Adverse Action at its next regular meeting following the waiver by the member.

SECTION 4. PRE-HEARING PROCESS

- a. Notice of Time and Place of Hearing - Upon receipt of a timely request for hearing, the Chief Executive Officer shall notify the member by special notice of the time, place and date of the hearing. The hearing will be held not sooner than 30 days and no later than 60 days after the date of the notice of hearing unless holding the hearing sooner than 60 days from the date of the notice is impractical. The notice shall also include a copy of the MEC's or the Board's (depending upon which body recommended the proposed Adverse Action), list of witnesses.
- b. Witnesses - Within 15 days of receipt of the notice of the hearing, the member shall provide the Review Panel with a list of witnesses expected to testify at the hearing on behalf of the member. Both parties may revise their witness lists with notice to the other party prior to the hearing, or during the hearing if authorized by the hearing officer.
- c. Appointment of Review Panel -
 1. Composition of Review Panel - the President of the Medical Staff, in agreement with the CEO, shall appoint a review panel comprised of at least 3 persons, and will select a chairperson from the appointed members. The Review Panel should be comprised of three members of the Hospital Medical Staff. However, if it is not possible to identify any or enough members of the Medical Staff to serve on the Review Panel, the Medical

Staff President, in agreement with the CEO, may appoint up to three physicians from outside the Medical Staff in order to obtain a three-member hearing committee to hear the matter at issue.

2. Eligibility for Review Panel - Consistent with the Conflict of Interest Policy of these bylaws, no Medical Staff member who has participated in the initiation of the case shall serve on the Review Panel, nor shall any individual who is in direct economic competition with the member serve on the review panel. However, the Review Panel may call as a witness members of the same medical specialty or subspecialty as the member in issue (who shall be subject to cross-examination by either party), and any member of the Medical Staff or other practitioner may appear before the Review Panel as a witness if requested by either party concerned. A Medical Staff member shall not be disqualified from serving on a review panel because he/she has heard of the case or has a basic knowledge of the facts involved in the case.
- d. Appointment of Hearing Officer - The President of the Medical Staff, in agreement with the CEO, may select the chairperson of the Review Panel as the Hearing Officer. Alternatively, in the discretion of the President of the Medical Staff, in agreement with the CEO, a separate Hearing Officer may be selected from a list of individuals. The Hearing Officer shall not be in economic competition with the member, and shall not currently represent, or within the prior twelve month period have represented, the Hospital, the Medical Staff or the Member, or be selected from within a law firm that currently represents, or within the prior twelve month period has represented, the Hospital, the Medical Staff or the member.

SECTION 5. CONDUCT OF HEARING

- a. Presiding Officer - The Hearing Officer shall preside over the hearing to determine the order of procedure during the hearing, to maintain decorum and to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and shall also be referred to as the Presiding Officer. The Presiding Officer shall make all rulings on matters of procedure, and the admissibility of evidence. If the Presiding Officer is the chairperson of the Review Committee, service as the Presiding Officer shall not prevent such individual from voting. However, if the Presiding Officer is not a member of the Review Panel, such individual shall not vote.
- b. Quorum - A simple majority of Review Panel members shall constitute a quorum. Action is taken by the affirmative vote of a simple majority of the Review Panel members present during a meeting or hearing at which a quorum exists. No member of a Review Panel may vote by proxy.
- c. Record of Hearing - A permanent record of the hearing shall be made by court reporter or electronic means, as determined by the Presiding Officer. A copy of the transcript shall be provided to both parties upon request. Additional copies can be requested at the cost of the party making the request.

- d. Personal Appearance - The personal appearance of the member requesting the hearing is required. A member who fails without good cause to appear and proceed at the hearing is deemed to have waived his or her rights to all hearing and appellate review protections under these bylaws, with the same consequences as Article VIII, Section 3 (Waiver of Hearing and Appeal Rights), above.
- e. Postponement - The hearing may be postponed by the Presiding Officer upon request, but only upon a showing of good cause.
- f. Representation - The member who requested the hearing is entitled to be represented at the hearing by an attorney, a member of the Medical Staff in good standing, or another person of the member's choice. The MEC, or Board, depending upon which body took the action or made the recommendation giving rise to the request for hearing, shall appoint one of its members, or in the case of the MEC, any Medical Staff member, to represent it at the hearing, and also may be represented by an attorney at the hearing. Additionally, the Review Panel may be advised by legal counsel. However, legal counsel may not influence the Review Panel's substantive review, other than to clarify its responsibilities. While legal counsel may attend and assist the respective parties in proceedings provided herein, due to the professional nature of the review proceedings, it is intended that the proceedings will not be judicial in form but rather a forum for professional evaluation and discussion. Accordingly, the Presiding Officer, and/or appellate review body, as applicable, may impose reasonable limits on the time allowed for legal counsel cross-examination and oral arguments, as well as reasonable limits on the number of witnesses called. Any member who incurs legal fees in his/her behalf shall be solely responsible for payment thereof.
- g. Rights of Parties - During a hearing, each of the parties shall have a right to:
 - 1. Present evidence deemed relevant by the Presiding Officer, and
 - 2. Call, examine and cross-examine witnesses.
- h. If the member who requested the hearing does not testify in his/her own behalf, he/she may be called and examined.
- i. Procedure and Evidence – Except as hereinafter provided, no right exists to discovery of documents or other evidence in advance of a hearing, but the Presiding Officer may confer with both parties to encourage and advance mutual exchange of documents relevant to the issues to be presented at the hearing. It shall be the duty of the member and the MEC or Board (depending upon which body recommended the proposed Adverse Action), or its designee, to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing. The hearing shall 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 on the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The focus of the Review Panel's deliberation and review shall be on the Adverse Action prompting the member's request for a hearing. However,

the Review Panel shall be entitled to consider evidence of prior events and/or actions to the extent they are relevant to the Adverse Action under review, such as any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the Medical Staff Bylaws and Policies, in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges; provided however, that the member under review shall be given notice of the evidence being considered prior to the hearing. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by the Presiding Officer and entitled to notarize documents. The Review Panel may allow the parties to submit written statements of the matter to the Review Panel prior to the hearing, and shall permit the parties to submit a written statement at the close of the hearing. The Review Panel shall establish the deadlines associated with the submission of such written statements.

- j. Burden of Proof – The body whose recommendation gave rise to the request for hearing shall have the initial obligation to present evidence in support thereof. The member shall thereafter be responsible for supporting a challenge to the recommended Adverse Action by a preponderance of the evidence that the grounds therefor lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable or capricious.
- k. Recesses and Adjournment - The Review Panel may recess the hearing and reconvene the same, without special notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Review Panel shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared officially adjourned.
- l. Review Panel Report - Within 30 days after final adjournment, the Review Panel shall make a written report of its findings and recommendations in the matter, stating the reasons for each recommendation, and shall forward the report, together with the hearing record, all other documentation considered by the Review Panel and a description of the process for appealing the decision, to the member and to the MEC or Governing Body, depending upon whose recommendation gave rise to the request for hearing.

SECTION 6. NOTICE OF APPELLATE REVIEW

- a. The affected member or the MEC or Governing Body, depending upon which body's action gave rise to the request for hearing, may within 7 days after the date of the notification of the Review Panel's recommendation, request appellate review. A request for appellate review must be in writing to the CEO and must include a statement regarding the reason(s) for the appeal. The CEO will forward the request to the chairperson of the Governing Body. If appellate review is not requested within 7 days after the date of the notification, the parties shall be deemed to have waived all rights to the same and the Review Panel's recommendation shall be forwarded to the Governing Body for final action.

- b. Upon receiving notice of request for appellate review, the Governing Body shall, within 7 days set a date, time and place for the meeting to conduct the appellate review, and shall promptly notify the member of the date, time and place for the review. The member will be notified of the appellate review meeting at least 10 days prior to the date set for such meeting.

SECTION 7. PROCEDURE FOR APPELLATE REVIEW

- a. The appellate review shall be conducted before an Appellate Review Committee comprised of a committee of the Governing Body selected by the Governing Body, and one member of the Appellate Review Committee shall be designated as Chair. The Chair shall determine the order of procedure during the appellate review, make all required rulings, and maintain decorum. The Appellate Review Committee shall have all powers granted to the Review Committee as well as such additional powers as are reasonably appropriate to the discharge of its responsibilities.
- b. No member of the MEC or Governing Body who participated on the Review Panel for the hearing on the matter in issue shall be a member of the Appellate Review Committee, and no member of the Appellate Review Committee may be in direct economic competition with the member. However, knowledge of the matters under consideration does not preclude any person from serving on the Appellate Review Committee.
- c. The appealing party shall, upon written request, be afforded access to such records and documents which have been considered by the various committees/panels hearing the matter. The appealing party may submit a written statement covering any matters raised at any step in the procedure to which the appeal is related. The written statement shall be submitted to the CEO for transmittal to the Appellate Review Committee and the other party by special notice at least seven (7) days prior to the appellate review meeting. The other party may also submit a written statement responding to the written statement submitted by the appealing party, and such responsive written statement shall be submitted to the CEO for transmittal to the Appellate Review Committee at least three (3) days prior to the appellate review meeting.
- d. Neither party is required to personally attend the appellate review meeting. However, if the parties personally attend, the appealing party shall be accorded reasonable time for oral argument, if desired, which time shall not exceed thirty (30) minutes excluding questions, and in the course of the oral argument, shall be required to answer questions asked by any member of the Appellate Review Committee. The other party shall also be permitted oral argument in favor of any adverse recommendation or decision, and shall also be required to answer questions asked by any member of the Appellate Review Committee.
- e. The parties may be represented by an attorney or other person of their choice before the Appellate Review Committee. The Appellate Review Committee may also be represented by legal counsel to the Hospital, however, legal counsel may not influence the Appellate Review Committee's substantive review, other than to clarify its responsibilities.

- f. The Appellate Review Committee shall review the record created in the proceedings, including the written statements submitted and the oral arguments, if any. Matters not raised during the original hearings nor otherwise reflected in the record shall only be introduced at the appellate review under unusual circumstances, and the Appellate Review Committee shall, in its sole discretion, determine whether such new matters shall be accepted.
- g. The Appellate Review Committee may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of oral arguments, if any, the appellate review shall be closed. The Appellate Review Committee shall then, at a time convenient to itself, conduct deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.
- h. The Appellate Review Committee shall submit a written report to the Governing Body with a recommendation that the Governing Body affirm, modify, or reject the Review Panel's recommendation. The Governing Body shall then render its final decision in the matter in writing, including an explanation of the reasons for its decision. The written report will be provided to the MEC, if the MEC is the body whose recommendation resulted in the request for a hearing, and to the affected member by special notice.
- i. The Governing Body's decision shall be final and shall be effective immediately. No member is entitled to more than one hearing and one appellate review on any matter.

SECTION 8. GENERAL HEARING PROVISIONS

- a. Time Limits - Any time limits set forth in the Hearing and Appeal procedures contained in these Bylaws may be extended or accelerated by mutual agreement between the parties. The time periods specified in these Bylaws for action by the Medical Staff, the Governing Body and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the Adverse Action if the hearing process is not completed within the time periods specified.
- b. Deviations from Procedures - Technical or insignificant deviations from the hearing procedures set forth in the Hearing and Appeal procedures contained in these Bylaws shall not be grounds for invalidating the action taken.

SECTION 9. REPORTING FINAL ACTIONS

Before final actions are reported to government, licensing or regulatory agencies as required by law, the member will, upon request, have an opportunity to meet with the Hospital's authorized representative and the President of the Medical Staff to review and discuss the contents of the report.

ARTICLE IX MEDICAL STAFF OFFICERS AND REPRESENTATIVES

SECTION 1. OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the following:

- President
- Vice-President/President-elect
- Secretary/Treasurer

SECTION 2. QUALIFICATIONS OF OFFICERS

Officers must be members of the active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

SECTION 3. ELECTION OF OFFICERS

- a. The Nominating Committee shall offer one or more nominees for each office, and notify those Medical Staff members eligible to vote of its nominees by October 1. Any additional nomination must be received in the Medical Staff office by November 1 and must be supported in writing by two Medical Staff members eligible to vote.
- b. Ballots will be sent out to the members of the Medical Staff eligible to vote 30 days before the December Medical Staff meeting.
- c. Officers are elected by a majority of the eligible members voting, given a quorum.

SECTION 4. TERM OF OFFICE

Officers shall take office on the first business day of the new calendar year and serve a two-year term until the first business day of the calendar year two years after assuming office.

Removal of an officer during the term of office may be initiated by a two-thirds majority vote of all eligible voting members of the Medical Staff. Removal of an officer shall be for just cause. Just cause may include but is not limited to the following:

- a. Failure to adhere to the Medical Staff bylaws, rules and regulations, and policies
- b. Professional conduct detrimental to the interests of the Medical Staff
- c. Failure to perform the duties of the office

SECTION 5. VACANCIES IN OFFICE

Except for the office of President of the Medical Staff, all vacancies occurring during the Medical Staff year shall be filled by the MEC. If there is a vacancy in the office of the President, the Vice President/President-elect shall serve out the remaining term.

SECTION 6. DUTIES OF OFFICERS

- a. President: The president shall serve as the chief administrative officer of the Medical Staff. Duties include:
1. Representing the interests of the Medical Staff in their role of service on the Governing Body, and in their activities where they interact with the CEO and Governing Body
 2. Calling, presiding, and being responsible for the agenda of all general meetings of the Medical Staff
 3. Serving as chairperson of the MEC. The President of the Medical Staff casts the tie-breaking vote in those instances where a tie vote exists
 4. Serving on the Governing Body as a voting member
 5. Serving as an ex-officio, non-voting member of all other Medical Staff committees unless otherwise stated in these Bylaws
 6. Responsibility for the enforcement of Medical Staff bylaws, rules and regulations, and policies for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a member or practitioner
 7. Appointing committee members to all standing, special, and interdisciplinary Medical Staff committees except the MEC
 8. Representing the views, policies, needs, and grievances of the Medical Staff to the Governing Body and to the CEO
 9. Reporting to the Governing Body on the quality of medical care provided by members of the Medical Staff as the individual responsible for the Medical Staff, with whom the Governing Body shall directly consult on all matters related to the quality of medical care provided to patients at the Hospital, and other matters of mutual concern.
 10. Assisting the general educational activities of the Medical Staff
 11. Serving as the spokesperson for the Medical Staff in its external professional and public relations
 12. Assisting in the development and periodic review of Medical Staff policies, rules and regulation
 13. Providing appropriate physician input regarding patient care policies and procedures
- b. Vice President/President-elect: In the absence of the President, the Vice-President shall assume all the duties and have the authority of the President. The Vice-president is a member of the MEC and of the Credentials Committee. The Vice-President shall automatically succeed the President when the latter fails to serve for any reason.
- c. Secretary-Treasurer: The secretary-treasurer is a member of the MEC and the Credentials Committee. They are responsible for producing accurate and complete minutes of all Medical Staff meetings, calling Medical Staff meetings on order of the President, attending to all necessary correspondence, and performing other duties as ordinarily pertain to the office.

SECTION 7. BOARD REPRESENTATIVES

There shall be a Medical Staff member on the Governing Body who shall serve a three-year term as a voting member. The membership qualifications for the medical staff's representative on the Governing Body shall be the same as those for general Governing Body membership. The MEC may submit to the Governing Body its recommendations regarding the Medical Staff member to serve on the Governing Body. However, the Governing Body is not bound by the MEC's recommendations, and the Governing Body shall make all decisions regarding appointment of a Medical Staff member to serve on the Governing Body.

ARTICLE X CLINICAL DEPARTMENTS

SECTION 1. ORGANIZATION OF CLINICAL DEPARTMENTS

Departments of the Medical Staff include: Anesthesia, Cardiovascular Medicine, Dental, Emergency Medicine, Family Medicine, Internal Medicine, Surgery, Obstetrics-Gynecology, Ophthalmology, Orthopedics, Pathology, Pediatrics, Podiatry, Psychiatry, Radiology and Urology. Each department shall be organized separately and shall have one chairperson. Subject to these bylaws, each department:

- a. May divide into a specialty section where there at least 3 members of that specialty.
- b. May request that a specialty section with 8 or more members be designated by the MEC as a separate clinical department of the Medical Staff with representation on the Medical Executive Committee.
- c. Once formed, must maintain at least 5 members to be represented on the MEC as a separate clinical department. A department whose number of members is less than 5 will relinquish its status on the MEC as a separate clinical department effective at the beginning of the next Medical Staff year.
- d. Where a recognized specialty section falls below 3 members, it will automatically relinquish its specialty designation at the beginning of the next Medical Staff year.

SECTION 2. QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIRPERSONS

- a. Each chairperson shall be a member of the Medical Staff in good standing, qualified by training, experience, and demonstrated ability for the position. Current board certification by an appropriate specialty board or comparable competence verified through the credentialing process is required.
- b. Each chairperson shall be elected by the department for a term of two-years or as determined by the department.

- c. Removal of a chairperson during the term of office may be initiated for just cause by a two-thirds majority vote of all eligible voting members of the department where a quorum is present as defined by these bylaws. No such removal shall be effective until it has been ratified by the MEC. The MEC may also remove a department chairperson for just cause. Just cause includes, but is not limited to the following:
 - 1. Failure to adhere to the Medical Staff bylaws, rules and regulations, and policies
 - 2. Failure to faithfully perform the duties of the office

SECTION 3. FUNCTIONS OF DEPARTMENT CHAIRPERSONS

Each chairperson shall:

- a. Be accountable for the oversight and improvement of the quality of care, treatment services provided by the department, and for the clinical performance of all members or practitioners assigned to the department.
- b. Serve as a member of the MEC, participate in the development and implementation of policies and procedures affecting the provision of care, treatment and services in the hospital.
- c. Review the professional performance of all members and practitioners with clinical privileges in the department.
- d. Make recommendations to the Credentials Committee and the MEC regarding the criteria for clinical privileges that are granted to members of the department. Department Chairs shall review and sign off on department delineation of privileges every three years.
- e. Enforce the Medical Staff bylaws, rules, and regulations, and policies within the department.
- f. Implement all MEC directives that pertain to the clinical activities of the department.
- g. Recommend the Medical Staff category, appointment/reappointment, and clinical privileges for all members and practitioners in the department.
- h. Be responsible for orientation, education, teaching and research programs within the department.
- i. Collaborate with Patient Care Services and hospital administration in related activities of the department. This includes:
 - 1. evaluating off-site resources for needed patient care
 - 2. evaluating services not provided by the department
 - 3. coordinating department activities with primary functions of the organization
 - 4. coordinating intradepartmental services
 - 5. recommending space, resources, and sufficient number of qualified and competent personnel to provide care, treatment and services

- j. Assist with and recommend services and programs to improve patient safety and patient satisfaction.

SECTION 4. FUNCTIONS OF DEPARTMENTS

- a. Each clinical department shall establish its own professional criteria, consistent with the policies of the bylaws, rules and regulations of the Medical Staff for granting clinical privileges. These criteria include:
 - 1. Evidence of current unrestricted licensure
 - 2. Evidence of relevant training, experience, and current competence
- b. Each clinical department shall participate in improving the care provided by all members and practitioners of the department.
- c. Each department will utilize monitoring and studies/projects to improve clinical process.
- d. Each clinical department shall communicate to the MEC relevant information regarding current issues being addressed by the department.

SECTION 5. ASSIGNING MEMBERS TO CLINICAL DEPARTMENTS

The MEC, after consideration of the recommendations of the department chairs and the Credentials Committee, shall recommend initial departmental assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

SECTION 6. ELECTION OF DEPARTMENT CHAIRPERSONS

The departments of internal medicine, surgery, pediatrics, anesthesia, cardiovascular medicine, family medicine, and psychiatry shall elect a chairperson and an assistant chair in the last scheduled meeting of the calendar year in odd-numbered calendar years or as determined by the department. Departments of obstetrics-gynecology, orthopedics, ophthalmology, pathology, podiatry, urology, radiology, emergency medicine, and dental shall elect a chairperson and an assistant chair in the last scheduled meeting of the calendar year in even-numbered calendar years or as determined by the department.

ARTICLE XI COMMITTEES

Every committee chair, and all department members are Medical Staff members, except as provided in these bylaws. Committee chairs must communicate with the MEC on all matters requiring MEC oversight. Committees must communicate with Medical Staff members in a timely fashion regarding committee business, and will respond to committee members' suggestions, complaints, requests and concerns.

Medical Staff Member Committees

Committee members and chairs are appointed by the President of the Medical Staff, based on expertise in the issues within the committee's purview and appropriate representation, subject to approval by the MEC. Committee members serve the term appointed unless they resign or are removed as permitted under these bylaws. All committee members shall act in good faith to carry out their committee responsibilities.

SECTION 1. MEDICAL EXECUTIVE COMMITTEE

The MEC is a standing committee and is comprised of:

- a. All officers of the Medical Staff
- b. Chairperson of each clinical department or the Assistant Department Chair in the Chair's absence.
- c. The immediate Past-President of the Medical Staff
- d. The CEO, designee, as ex-officio members-at-large without vote

The duties of the MEC are delegated by the Medical Staff and include:

- a. Represent and act on behalf of the Medical Staff, including between Medical Staff meetings, subject to such limitations as may be imposed by these bylaws;
- b. Review, as necessary, the activities and general policies of the clinical departments;
- c. Receive and act on committee reports and recommendations of clinical departments and other assigned responsibilities;
- d. Review, approve and implement policies of the Medical Staff that are applicable across clinical departments and impact patient care and safety;
- e. Act as a liaison between Medical Staff, and the CEO and the Governing Body;
- f. Recommend action to the CEO on matters of a medico-administrative nature including advising the CEO and Governing Body on the selection of administrative staff who may influence the quality of care being provided by the practitioners and members at the hospital;
- g. Review the credentials of all applicants and make recommendations to the Governing Body for staff membership, departmental assignments, and delineation of clinical privileges;
- h. Periodically review all available data regarding the performance and clinical competence of staff members and other practitioners with clinical privileges;
- i. Make recommendations to the Governing Body for appointments to, or renewal or membership on the Medical Staff;
- j. Make recommendations to the Governing Body for granting, restricting, or denying clinical privileges;
- k. Make recommendations to the Governing Body regarding the Medical Staff structure/organization, function, Medical Staff membership and approval of clinical privileges;
- l. Fulfill the Medical Staff's accountability to the Governing Body;
- m. Receive and disseminate information from accrediting bodies to the Medical Staff;
- n. Support medical education programs;

- o. Take all reasonable steps to maintain professional and personal conduct on the part of all members of the Medical Staff, by adhering to the standards of the Medical Staff embodied in these bylaws;
- p. Participate in peer review activities, and Medical Staff correction or review measures when warranted;
- q. Report to the Medical Staff at each general staff meeting regarding Medical Staff activities;
- r. Review and act on department recommendations for improving patient safety and patient satisfaction;
- s. Evaluate resource allocation on an interdepartmental basis and recommend changes in staffing, space and other hospital resources as needed to support privileges for which criteria have been approved by the MEC;
- t. Advise the Governing Body on the quality of patient care;
- u. Provide input to the Governing Body on existing and proposed agreements between Mercy Medical Center and its Medical Staff members, or other practitioners exercising clinical privileges, or any entity where these agreements can affect the quality of patient care; and
- v. Meet monthly and maintain a permanent record of its proceedings and actions. For the purpose of decision making, a quorum must be present, and is met whenever at least 50% of all eligible MEC voting members are present in person.
- w. Department Chair orientation shall be held at the December General Medical Staff meeting and at the January meeting of the Medical Executive Committee. All new members of the Medical Executive Committee and new Assistant Department Chairs are required to attend one of the two orientation sessions. New Department Chairs and Assistant Department Chairs shall not be seated until they have attended one of the two orientation sessions. All current members of the Medical Executive Committee are invited to attend orientation to provide additional guidance and support

The Medical Staff can remove the MEC's delegated authority temporarily, as appropriate to protect the Medical Staff's interests, by vote of at least two-thirds of the membership.

SECTION 2. CREDENTIALS COMMITTEE

- a. The Credentials Committee shall consist of at least five members including the Vice President and Secretary/Treasurer of the Medical Staff as well as at least three Past Presidents of the Medical Staff. The current President of the Medical Staff serves as an ex-officio member without vote. The VPMA may attend the meeting and, when present, serve as an ex officio member without vote. The chairperson of the committee will be selected from one of the Past Presidents.
- b. The duties of the Credentials Committee include:
 - 1. Review the credentials of all applicants and to make recommendations to the MEC for membership and delineation of clinical privileges in compliance with these bylaws. Where relevant, the review shall include specific consideration of the recommendations of the department chair in which such applicant requests privileges;
 - 2. Periodically review all current information available regarding the current clinical competence of Medical Staff members previously granted clinical privileges. This review will assist the Credentials Committee in making recommendations affecting

- clinical privileges, reappointment to the Medical Staff, and the assignment of members and practitioners to the clinical departments as provided in these bylaws;
3. Review information referred by the President of the Medical Staff or from the MEC or other Medical Staff committees;
 4. Promulgate, review and recommend to the MEC policies and procedures related to the credentialing process; and
 5. Review and recommend criteria for clinical privileges.
- c. The Credentials Committee shall meet as necessary to conduct business, and shall maintain a permanent record of its proceedings and actions. Attendance of at least 50% of voting members shall constitute a quorum for decision-making purposes.
- d. The Credentials Committee's report to the MEC on its actions and recommendations is included in the regular MEC report to the Governing Body.

SECTION 3. BYLAWS, RULES AND REGULATIONS COMMITTEE

- a. The Bylaws, Rules and Regulations Committee shall consist of six members of the active Medical Staff.
- b. This committee shall review the bylaws, rules and regulations and all rules and regulations and policies of the Medical Staff and of each department and section at least annually and as needed to determine that they are complete, current and not in conflict with one another. The committee, with the assistance of outside, independent Medical Staff legal counsel when necessary, shall assist in the interpretation of these bylaws, rules, and regulations and recommend changes, as necessary, to the MEC. The bylaws committee annually reviews Medical Staff forms and any proposed changes to them, which may include the application, leave of absence form and the additional privileges application, to determine that the forms remain current and continue to reflect the Medical Staff governance documents.

SECTION 4. NOMINATING COMMITTEE

- a. The three most recent available Past-Presidents of the Medical Staff shall serve as Nominating Committee members. The chairperson will be the third Past-President.
- b. The committee shall present a slate of officers to the Medical Staff at the December meeting of each Medical Staff year. The slate shall include the President, Vice-President/President-Elect, and Secretary/Treasurer.

SECTION 5. MEDICAL STAFF WELLNESS COMMITTEE

- a. A chemical dependence, mental or physical illness or other impairment may affect a Medical Staff member's ability to practice with reasonable skill and safety to patients and staff. The Medical Staff Wellness Committee exists to provide a non-punitive approach to assist Medical Staff with matters of individual physical and mental health and to proactively maintain a healthy Medical Staff. However, if at any time it is determined that

a member is unable to safely perform the Privileges he or she has been granted, or if it is determined that the member's behavior or actions so warrant, the matter shall be forwarded for appropriate correction action under these bylaws. The Wellness Committee seeks to maintain the ability of all members and practitioners to practice with reasonable skill and safety not limited by physical or mental disorders or disabilities.

1. The committee receives reports from any source regarding possible impairment of a member, including self-referrals, and screens out specious or inappropriate reports.
2. As appropriate, the committee refers members to medical, psychological or surgical specialists, or other sources, for evaluation and treatment of condition affecting the member's ability to safely practice.
3. The committee assists members with post-evaluation and treatment monitoring. Referrals, monitoring and all member-related activity by the committee and its members is confidential.
4. When needed, confidential reports to the MEC are provided that offer information limited to the ability of the member or practitioner to function in a safe and competent manner. Should a member or practitioner fail to comply with treatment plans and monitoring or otherwise jeopardize patient safety, the committee refers the member or practitioner to the MEC for corrective action.
5. The committee organizes staff-wide education about professional impairment issues.

The Committee will consist of at least 3 members as follows; 1 (one) Administrator from the Medical Center; 2 (two) other members of the Medical Staff with 5 or more years of service on the Medical Staff. Consideration should be made that one of the Medical Staff members have experience in behavioral health and/or substance abuse evaluation and treatment. The term of service will be determined by the MEC. No member of the Wellness Committee shall serve on other Peer Review or Quality Committees in the Hospital during the time they are serving on the Wellness Committee.

Multi-Disciplinary Committees

Medical Staff members of these committees are appointed by the President of the Medical Staff, subject to the approval of the MEC. Governing Body members of these committees are appointed by the Chairperson of the Governing Body. Administrative members of these committees are appointed by the CEO.

SECTION 6. CANCER COMMITTEE

- a. The Cancer Committee shall consist of at least physician representatives from pathology, medical oncology, diagnostic radiology, radiation oncology, urology, surgery, and cancer liaison physician. Non-physician membership shall include the cancer program administrator, oncology nurse, social worker or case manager, certified tumor registrar (CTR), quality management professional, and pain control/palliative care specialist.
- b. The committee shall:
 1. Oversee the medical center's cancer program.
 2. Develop and evaluate goals for clinical, community outreach, quality improvement, and program endeavors related to cancer care.

3. Carry out any additional functions consistent with the current requirements of the American College of Surgeons Commission on Cancer.
- c. Committee meetings will be held at least quarterly and members shall attend at least 50% of the meetings annually.
- d. Attendance of at least 50% of the voting members shall constitute a quorum for decision-making purposes.

SECTION 7. JOINT CONFERENCE COMMITTEE

The committee is the forum in which the Medical Staff and Governing Body resolves any disputes and may accept requests to resolve differences between or among other Medical Staff and/or hospital leaders. The Joint Conference Committee is comprised of the non-conflicted Medical Staff members and an equal number of Governing Body who are neither Medical Staff members nor hospital employees. The Joint Conference Committee may review proposed strategic plans before they are implemented, and may request additional information from administration prior to final approval by the Governing Body. The committee may request additional information from throughout the hospital community to assist in the resolution of disputes. Either the MEC or the Governing Body can refer plans and disputes to the Joint Conference Committee. The Joint Conference Committee fulfills other responsibilities set forth in these bylaws. The recommendations of the Joint Conference Committee shall be submitted for review and recommendation by the MEC at its next meeting or within thirty (30) days, whichever is sooner, and at such MEC meeting the MEC shall review and provide a recommendation to the Governing Body for final action.

ARTICLES XII MEDICAL STAFF MEETINGS

SECTION 1. REGULAR MEETING

An annual meeting of the Medical Staff shall be held in December of each year. At this meeting, the retiring officers shall make such reports as deemed necessary. Election of officers shall take place at this meeting.

The MEC may hold regular meetings of the Medical Staff for the purpose of transacting business that comes before the Medical Staff. All regular meetings of the Medical Staff shall be held at a place and time that the President of the Medical Staff designates. The notice for regular meetings of the Medical Staff shall be provided in writing to members at least 3 weeks in advance of the meeting date.

SECTION 2. SPECIAL MEETING

Special meetings are called to discuss issues of interest to the Medical Staff, including addressing and managing conflicts between the Medical Staff and its MEC.

- a. The President of the Medical Staff or the MEC may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within seven days after receipt of a written request for a meeting signed by at least 30% of the eligible voting members of the Medical Staff. The President of the Medical Staff shall call special meetings initiated by the President of the Medical Staff, the MEC, or the Medical Staff no sooner than thirty days in advance of the date of the notice. The MEC shall designate the time and place of any special meeting.
- b. Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, or email, to each member of the voting Medical Staff, along with an agenda for the meeting. The attendance of a voting member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 3. QUORUM

A quorum requires that at least 30% of the eligible voting members of the organized Medical Staff cast ballots in person or by written proxy at any regular or special meeting. If a member cannot physically attend a regular or special meeting, but would like to vote on one or more issues specified in the notice of the meetings, the member may do so by written proxy. Proxy forms shall be available at least 15 days prior to the meeting. If a quorum is not achieved by in-person attendance (counting any written proxies) at a regular or special meeting, then the meeting may be adjourned and the vote taken by mail or electronic means to be completed within thirty (30) days of the meeting. No proxies are permitted in mail or electronic balloting. In the event of mail or electronic balloting, a quorum requires at least 30% of the eligible voting members of the organized Medical Staff to cast ballots. In the event a quorum is not reached either through the in-person voting at a meeting or through the mail or electronic balloting on the issue, a special meeting of the Medical Staff will be called for the purpose of producing an effective vote.

SECTION 4. AGENDA

- a. An agenda shall be prepared and distributed to the Medical Staff one month in advance for regular Medical Staff meetings. This agenda will list the issues requiring Medical Staff recommendation/action.
- b. The agenda at special meetings shall include the reading of the notice calling the meeting and transaction of the business for which the meeting was called.

SECTION 5. MANNER OF ACTION

Unless otherwise set forth herein, the action of a majority of the members present in person or by proxy at a regular or special meeting at which a quorum is present shall be the action of the Medical Staff. As an alternative to taking action at a meeting, action may be taken without a meeting by means of a majority vote of mailed ballots signed by each member entitled to vote where a quorum is present as defined by these bylaws. Notice, attendance, and actions including voting and

participation may be accomplished by email or other electronic and/or telephonic means where permitted by the chair of the meeting on either an individual or group basis.

SECTION 6. ATTENDANCE REQUIREMENTS AND PROXY VOTING

If a member cannot physically attend a regular or special meeting, but would like to vote on one or more issues specified in the notice of the meetings, the member may do so by written proxy. Proxy forms shall be available at least 15 days prior to the meeting.

ARTICLE XIII COMMITTEE AND DEPARTMENT MEETINGS

SECTION 1. REGULAR MEETINGS

Committees may, by resolution, specify the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at a time and a frequency determined by the members. At regular department meetings, emphasis shall be placed on issues most directly impacting the quality of care and services provided.

SECTION 2. SPECIAL MEETINGS

A special meeting of any committee or department may be called by or at the request of the Chairperson, by the President of the Medical Staff, or by one-third of the group's current members, but not less than two members.

SECTION 3. NOTICE OF MEETINGS

Written, oral or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than five (5) business days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, postage prepaid, addressed to the member at his or her address as it appears on the records of the hospital. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 4. QUORUM

The eligible voting members of the Medical Staff present at any committee, or department meeting, but no fewer than three, unless otherwise designated in these bylaws, shall constitute a quorum.

SECTION 5. MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. As an alternative to taking action at a meeting, action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote. Committee action may be conducted by telephone conference that shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Notice, attendance, and actions including voting and participation may be accomplished by email or other electronic and/or telephonic means where permitted by the chair of the meeting on either an individual or group basis.

SECTION 6. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these bylaws as ex-officio members of a committee, unless otherwise provided in these bylaws, shall not have the right to vote or be counted toward the quorum, but may participate at the will of the chair.

SECTION 7. MINUTES

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and approved at the next regular meeting. The approved minutes shall be made available to the President of the Medical Staff for review and communication at the MEC, as appropriate. A permanent file of the minutes of each meeting shall be maintained for all committees and departments.

SECTION 8. MEETING FREQUENCY AND ATTENDANCE REQUIREMENTS

- a. Each department shall determine the meeting frequency and attendance requirements.
- b. The MEC Medical shall meet monthly as defined in these bylaws. Attendance at each meeting is expected.

SECTION 9. EXECUTIVE SESSION

At the request of any member of the committee, or at the request of its chair, the committee will excuse all non-Medical Staff committee members for the purpose of closed discussion by the Medical Staff on the committee.

SECTION 10. PARLIAMENTARY AUTHORITY

The currently revised Robert's Rules of Order governs all meetings and elections to the extent they do not conflict with these bylaws, the Medical Staff rules and regulations or policies. Technical or insignificant deviations from Robert's Rules of Order do not serve to render actions invalid.

ARTICLE XIV IMMUNITY FROM LIABILITY

The following shall be express conditions to any member or practitioner's application for, or exercise of, clinical privileges at this hospital:

- a. That any act, communication, report, recommendation, or disclosure, with respect to any such member or practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged at the fullest extent permitted by law.
- b. That such privilege shall extend to members of the hospital's Medical Staff and to its Governing Body, its other practitioners, its CEO and his or her representatives, and to third parties who in good faith and without malice supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested by, or provided to, an authorized representative of the Governing Body or of the Medical Staff.
- c. That there shall be, to the fullest extent permitted by law, immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where information involved would otherwise be deemed privileged.
- d. That such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited, to:
 1. Applications for appointment or clinical privileges
 2. Periodic reappraisals for reappointment or clinical privileges
 3. Corrective action, including summary and automatic suspension
 4. Hearing and appellate reviews
 5. Medical care evaluations
 6. Utilization review
 7. Other hospital, departmental, service, or committee activities related to quality patient care and professional conduct
- e. That the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a member or practitioner's professional qualifications, clinical competency, mental or physical health condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.
- f. That in furtherance of the foregoing, each member or practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in this section of the bylaws, subject to requirements including those of good faith, absence of malice, and the exercise of a

reasonable effort to ascertain the truthfulness, as may be applicable under the laws of this state.

- g. That the consents, authorizations, releases, rights, privileges and immunities provided by these bylaws for the protection of this Hospital's members and practitioners, other appropriate Hospital officials and personnel, and third parties, in connection with applications for initial appointment and reappointment, shall also be fully applicable to the activities and procedures covered by this Article.
- h. That the Hospital agrees to indemnify and otherwise cover the reasonable costs of defense, and of any settlements, judgments, and damages incurred by any member or practitioner acting in good faith and without malice as a result of carrying out duties under these bylaws, Medical Staff rules and regulations and policy.

ARTICLE XV ALLIED HEALTH PRACTITIONERS

Allied health practitioners (“AHPs”) are not members of the Medical Staff but are subject to the Medical Staff bylaws, rules and regulations, and policies.

SECTION 1. PRIVILEGES

AHPs who wish to be designated as independent ARNPs are credentialed and may be privileged through the Medical Staff process, and are assigned to Medical Staff departments according to the privileges granted and services provided.

Physicians supervising AHPs who provide patient services must apply for and be granted AHP supervising privileges. Only active Medical Staff physician members may be granted AHP supervising privileges. Physicians cannot supervise procedures and services that they do not have clinical privileges to provide. Physicians who fail to provide adequate supervision are subject to practice review and corrective action consistent with these bylaws.

SECTION 2. ACTIONS AFFECTING PRIVILEGES

For any change in Medical Staff membership status, supervisory privileges, or supervising or other relevant clinical privileges by the AHP's supervising physician, the AHP's privileges are automatically suspended. The AHP has sixty days to provide the Medical Staff office with appropriate documentation to reestablish the member relationship necessary for the privileges held. If the AHP does not provide the necessary documentation within sixty days, the clinical privileges of the Allied Health Provider immediately and automatically terminate and do not entitle the AHP to a hearing.

SECTION 3. MEETING PROCESS

Whenever the MEC or the Governing Body makes a recommendation or takes an action to deny an AHP's application, to terminate or summarily suspend an AHP's clinical privileges, or to restrict any or all privileges for more than thirty days, the CEO, or designee, provides the AHP

special written notice of the recommendation or action, the reasons for it, and the time period within which the AHP can request a single meeting to discuss the matter. If the AHP fails to timely request a meeting, the AHP's right to a meeting shall be waived. The AHP's right to a meeting maybe forfeited if the AHP fails to appear at the scheduled meeting without good cause. However, an AHP does not have a right to the Hearing and Appeals process set out in these bylaws for Medical Staff members. The special notice to the AHP shall state that the AHP does not have rights to the Hearing and Appeals process set out in the Medical Staff bylaws for Medical Staff members, and that the AHP shall be deemed to waive the right to a meeting if the AHP does not timely request the meeting or fails to appear at the scheduled meeting without good cause. If the AHP requests a meeting, the President of the Medical Staff selects and the VPMA appoints a committee comprised of at least three (3) unbiased Medical Staff members and/or AHPs with Clinical Privileges at the Hospital, to hear the AHP's objections to the proposed action or recommendation. The committee shall establish the rules for the meeting, in advance of the meeting, and shall communicate those rules to the AHP. It is intended that the meeting will not be judicial in form but rather a forum for professional evaluation and discussion between members of the committee and the AHP. During the meeting, the AHP shall have the right to receive an explanation of the recommendation or action upon which the meeting is based, and to submit any additional information to the committee that the AHP and the committee deem relevant to the review of the recommendation or action. After the meeting, the committee shall make a written recommendation, including an explanation of the basis for its recommendation, to the Governing Body for final action. The committee's written recommendation shall also be delivered to the AHP. The AHP shall have the right to one appeal of the committee's recommendation to the Governing Body. Final actions regarding AHPs are not reported to the National Practitioner Data Bank.

ARTICLE XVI EFFECT OF HOSPITAL SYSTEM PARTICIPATION

SECTION 1. UNIFICATION WITH OTHER MEDICAL STAFFS

The Medical Staff can be included in a unified medical staff of any health system in which the Hospital participates only after

- a. 4 months' prior written notice to all Members describing the proposed unification, setting forth its risks, benefits and effects to the Medical Staff and its members;
- b. Review and study, the Medical Executive Committee concurs based on favorable recommendations from a majority of all Departments;
- c. Vote to accept unification by two-thirds of eligible voting Members, cast at a special meeting called for that purpose, or via confidential mail ballot, as determined by the Medical Executive Committee.

If these requirements are not met, the Medical Staff shall remain separate from any system unified hospital and continues as the Medical Staff of the Hospital.

If the Medical Staff votes to accept unification, these Medical Staff Bylaws will remain in effect as to the Members, until the Bylaws are amended or new Bylaws adopted pursuant to the terms of these Bylaws.

SECTION 2. DISUNIFICATION

The Medical Staff shall disunify from any system unified medical staff by vote to disunify by two-thirds of eligible voting Members with privileges at the Hospital. The Medical Staff shall be the unique Medical Staff of the Hospital effective immediately, operating under the Medical Staff Bylaws in effect prior to unification.

ARTICLE XVII RULES AND REGULATIONS, AND POLICIES

The policies, rules and regulations of the Medical Staff and any Medical Staff department may not conflict with the Medical Staff bylaws. Where there is an apparent conflict with the bylaws, the language in the Medical Staff bylaws will, in all cases, be controlling.

SECTION 1. RULES AND REGULATIONS; MEDICAL STAFF POLICIES

The Medical Staff shall adopt such rules, regulations and policies as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the Governing Body. These rules, regulations and policies shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required for each member or practitioner in the hospital. Such rules, regulations and policies shall be a part of these bylaws. Amendments to the rules, regulations and policies of the Medical Staff shall only become effective when approved by the Governing Body. Neither the organized Medical Staff nor the Governing Body may unilaterally adopt, amend, approve, modify or enact changes to the Medical Staff rules and regulations.

SECTION 2. SUBSTANTIVE AMENDMENTS TO RULES, REGULATIONS AND POLICIES

The voting members of the Medical Staff may adopt such rules, regulations or policies and amendments thereto as they deem appropriate by a majority of votes cast by the Medical Staff Members eligible to vote, and once approved, may propose such rules and regulations and amendments thereto directly to the Governing Body. However, the voting members of the Medical Staff must first communicate the proposal to the MEC. The voting process for adopting rules, regulations or policies and amendments thereto is the same process as set out in these Bylaws for votes regarding amendments to these Bylaws.

SECTION 3. TECHNICAL AMENDMENTS TO RULES, REGULATIONS AND POLICIES

The MEC is authorized to enact technical, non-substantive changes to Medical Staff rules, regulations or policies without formal approval by the Medical Staff or the Governing Body provided the changes do not impact on the rights, duties and obligations arising under these bylaws, such as amendments that are technical modifications, clarifications, reorganization or renumbering or amendments necessary because of spelling, punctuation or other errors of grammar or expression. The MEC will notify all members of the organized Medical Staff, as well as the Governing Body through the CEO, in writing of all technical, non-substantive changes to the rules,

regulations or policies and such technical non-substantive changes shall stand unless objection is raised, in which case, such objected-to change shall not take effect, but rather shall be proposed through the amendment process for rules, regulations and policies set out above.

ARTICLE XVIII MEDICAL STAFF CONFLICT RESOLUTION

To provide a mechanism to resolve disagreements between Medical Staff members and the MEC or Governing Body, and provide a forum for discussing matters of common interest to the Medical Staff and the Governing Body.

a. **Resolving Conflicts Between Medical Staff and Governing Body**

In the event of a disagreement or impasse between the Medical Staff and the Governing Body, The Joint Conference Committee described in these Bylaws shall be called by either of the two parties. Matters arising under the fair hearing and appeals process are not presented to this committee.

b. **Resolving Conflicts Between the Medical Staff and MEC**

Except for actions of the MEC related to peer review under these bylaws, any action or recommendation of the MEC may be overturned by a majority vote of the eligible voting members of the Medical Staff through the following procedure:

1. Any voting member of the Medical Staff may request a vote to overturn actions or recommendations of the MEC. Any such request will be made in writing to the MEC no later than 180 days following the MEC action that is the subject of controversy.
2. The request to vote to overturn an MEC action must be approved by either a majority vote of the eligible voting Medical Staff members present at any regular or special meeting where a quorum is present as defined by these bylaws, or by a petition signed by at least 30% of the voting Medical Staff.
3. If the request is approved, a vote to overturn a MEC action may be undertaken at any regular or special meeting of the Medical Staff.
4. At least 15 days before any such meeting to overturn a MEC action, all eligible voting members of the Medical Staff will be given written notice of the meeting which will include the time and place of the meeting, and will include a written absentee ballot by double envelope system or secure anonymous electronic means.
5. All voting will be either in person at the time of the meeting, or by delivering the signed written absentee ballot or secure anonymous electronic absentee ballot to the Medical Staff office prior to the meeting.
6. A vote to overturn the MEC action will require the affirmative vote to overturn by a simple majority of the eligible voting Medical Staff where there is a quorum as defined by these bylaws.

ARTICLE XIX MEDICAL STAFF BYLAWS AMENDMENTS

These bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to the Bylaws Committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. The Medical Staff may also adopt amendments to the Medical Staff bylaws to be recommended for adoption by the Governing Body, without prior review or action by the Bylaws Committee or MEC.

To be adopted, an amendment shall require a two-thirds vote of eligible voting members of the Medical Staff either in person or by proxy, at a regular or special meeting. Alternatively, upon request of the members, these bylaws may be amended without a meeting by written or electronic ballot sent to each eligible voting member of the Medical Staff. Written ballots received back must be in ballot envelopes signed by the Medical Staff member. Electronic ballots shall be managed by an impartial vendor. At least 50% of the eligible voting members must be present at a regular or special meeting, or at least 50% of eligible voters must return ballots in order for the vote to be valid. At least two-thirds of the received ballots must indicate approval of the amendment for its adoption. Only those amendments adopted by the Medical Staff shall be effective, and only when approved by the Governing Body, whose approval shall not be unreasonably withheld.

Neither the organized Medical Staff nor the Governing Body may unilaterally adopt, amend, approve, modify or enact changes to the Medical Staff bylaws. Medical Staff members are bound solely by Medical Staff bylaws, rules and regulations, and policies.

ARTICLE XX ADOPTION AND EFFECT

These bylaws, together with the appended rules and regulations, shall be adopted at any regular or special meeting of the Medical Staff, shall replace any previous bylaws, rules and regulations, and shall become effective when approved by the Governing Body of the hospital.

These bylaws, as adopted or amended, create a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital, which the Medical Staff members and the Hospital intend to follow. Medical Staff members agree to follow the Medical Staff bylaws, rules and regulations, and policies, promulgated as defined under these Medical Staff bylaws.