

MERCYONE DUBUQUE MEDICAL CENTER

DUBUQUE, IOWA

MEDICAL STAFF BYLAWS

AND

RELATED DOCUMENTS

REVISIONS APPROVED by MercyOne Dubuque Medical Center Medical Staff 2019, 2022, 2023

REVISIONS APPROVED by MercyOne Dubuque Medical Center Board of Trustees 2019, 2022, 2023

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MERCYONE DUBUQUE MEDICAL CENTER

DUBUQUE, IOWA

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, MercyOne, Dubuque, Iowa, is a Member Organization of Trinity Health, a Michigan not-for-profit organization, and is authorized to do business in the State of Iowa; and

WHEREAS, its purpose is to serve as a general hospital providing patient care and education at a level of quality and efficiency consistent with the generally accepted community standards; and

WHEREAS, there is an expectation that members of the MercyOne Medical Staff shall assist the institution's mission and value of service to the indigent; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care at MercyOne and must accept and discharge this responsibility subject to the ultimate authority of the Trinity Health Board of Directors with delegated authority to the MercyOne Board of Trustees; and

WHEREAS, the cooperative efforts of the Medical Staff, the Hospital President and the Board of Trustees are necessary to fulfill MercyOne's obligation to its patients; and

WHEREAS, MercyOne's Board of Trustees and management require a source of collective advice from the practitioners at the health care facility regarding formulation and enforcement of institutional policy, planning, coordination of services and governance;

WHEREAS, the practitioners practicing in this hospital hereby organize themselves into a single Medical Staff in conformity with these Bylaws and the related manuals, policies, and rules and regulations. These Bylaws are intended solely for use as a means of Medical Staff governance and expressly do not constitute a contract between MercyOne and any practitioner.

DEFINITIONS

1. MercyOne means MercyOne Dubuque Medical Center.
2. PHYSICIAN means an individual with an M.D. or D.O. degree who is licensed in the state of Iowa to practice medicine.
3. DENTIST means an individual with a D.D.S. or D.M.D. degree who is licensed in the state of Iowa to practice dentistry.
4. PRACTITIONER means, unless otherwise expressly provided, any Iowa licensed physician, dentist, podiatrist or doctoral level psychologist applying for or exercising clinical privileges at MercyOne.
5. MEDICAL STAFF means, in a broad sense, a collective description of all practitioners who have been approved by the Board for one of the categories of membership as described hereafter in these Bylaws. However, unless otherwise expressly noted, it will specifically mean those required to attend meetings, serve on committees, pay dues, and who are eligible to vote in all medical staff affairs (i.e., Active Medical, Dental and Associate Medical).
6. BOARD means the MercyOne Board of Trustees which is the body established and appointed by the Trinity Health Board of Directors to perform and carry out those duties and responsibilities attributable to the Member Organization in the Trinity Health Bylaws.
7. EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff as defined in these Bylaws unless specific reference is made to the Executive Committee of the Board.
8. Hospital President (Hospital President) means the individual appointed by the Trinity Health Board of Directors to act on its behalf in the overall management of the hospital. Wherever the term "Hospital President" is used in these Bylaws, it shall include persons designated by the Hospital President to act in his or her behalf.
9. ADMITTING PRIVILEGES mean the authority to hospitalize patients that is granted to Medical Staff members who assume and discharge overall clinical responsibility for their patients' care.
10. CLINICAL PRIVILEGES mean the permission granted to a Medical Staff member to order or perform specific diagnostic, therapeutic, medical, dental or surgical services.
11. PRACTICE PRIVILEGES mean the permission granted to an Allied Health Professional or Medical Assistant to participate in the provision of certain patient care services.
12. ALLIED HEALTH PROFESSIONALS mean those individuals other than members of the

Medical Staff who possess a license, certificate, or other credentials required by Iowa law and who are approved by the Board to provide patient care services in MercyOne under the sponsorship and direction of a member of the Medical Staff. (See the Credentials Manual).

13. MEDICAL STAFF ASSISTANTS mean those individuals who do not possess a state license or other certification but are trained to perform certain health related tasks as approved by the Board under the sponsorship and direction of a member of the Medical Staff. (See the Credentials Manual).
14. CREDENTIALING AND PRIVILEGING MANUAL means a manual that delineates the credentialing and privileging process and procedures of the credentialing program which is incorporated by reference as part of the Bylaws.
15. POLICIES AND PROCEDURES MANUAL means a manual that delineates the policies and procedures that govern the day-to-day activities of the Medical Staff and which is incorporated by reference as part of the Bylaws.
16. FAIR HEARING PROCEDURE MANUAL means a manual that delineates methods for review, hearing and appeal of certain types of recommendations made or actions taken with respect to Medical Staff membership and/or clinical privileges and which is incorporated by reference as part of the Bylaws.
17. MEDICAL STAFF YEAR means the twelve (12) month period commencing on January 1 each year and ending December 31 of the same year.
18. SPECIAL NOTICE means a written notification sent by certified mail, return receipt requested, or by special delivery with signed acknowledgment.
19. WRITTEN means either on paper or electronically within the patient record.
20. SIGNED means affixing your signature either on paper or electronically.
21. TELEMEDICINE means the use of medical information exchanged from one site to another via electronic communication to improve patients' health status.

ARTICLE I: NAME

Practitioners privileged to attend patients pursuant to these Bylaws shall be referred to as the Medical Staff of MercyOne.

ARTICLE II: PURPOSES OF THE MEDICAL STAFF

- A. The organized medical staff enforces the Medical Staff Bylaws and Policies and Procedures by recommending action to the governing body in certain circumstances and taking action in others;
- B. To make recommendations to the governing Board regarding credentialing, quality assessment and peer review activities;
- C. To be responsible and accountable to the Board for the discharge of the duties and responsibilities delegated to it by the Board;
- D. To provide all patients admitted to, or treated in, any of the facilities, departments, or services of the units of MercyOne, care that is consistent with generally recognized standards of care;
- E. To monitor a high level of professional performance by all practitioners who are members of the medical staff, through the appropriate delineation of clinical privileges, and through an ongoing review and evaluation of each practitioner's performance in the units of MercyOne;
- F. To provide all members an appropriate educational setting that will maintain medical standards and lead to advancement and professional knowledge and skill;
- G. To initiate and maintain on an ongoing basis the Bylaws, Policies and Procedures for the self-governance of the Medical Staff;
- H. To provide a means by which members of the Active Medical Staff can work with the Board and MercyOne's Hospital President for the joint solution of medical/administrative problems and provide recommendations for MercyOne's policy making and planning process;
- I. To cooperate with affiliated medical schools and other educational institutions in undergraduate, graduate and post-graduate education; and
- J. To encourage and participate in programs of clinical research to develop improved methods of patient care.
- K. The Code of Conduct guides the management of conflict between the Medical Staff and the Medical Staff Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation or policy, or an amendment. The Board of Directors has ultimate

authority to resolve conflict.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

- A. Membership on the Medical Staff is a privilege granted by the Board that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements required by State of Iowa and federal law and these Bylaws.
- B. Membership on the Medical Staff may be revoked at any time by the Board as provided for by the procedures set forth in these Bylaws and the governing documents of MercyOne.

Section 2. Criteria for Membership

- A. Only practitioners licensed to practice in the State of Iowa who can document the following shall be qualified for Medical Staff membership:
 - 1. appropriate education and training, background and experience, and professional competence;
 - 2. is not excluded from any federal health care program such as Medicare or Medicaid;
 - 3. adherence to the ethics of the practitioner's profession as defined by appropriate professional societies;
 - 4. good personal and professional reputation;
 - 5. satisfactory physical and mental health;
 - 6. adequate professional liability insurance coverage as defined by MercyOne;
 - 7. ability to work with others; and
 - 8. all other information relevant to the provision of medical care and participation as a medical staff member of a unit of MercyOne as defined through the application process of the Credentials Manual.
- B. Documentation of satisfaction of these criteria must be presented with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by the practitioner at MercyOne will be given care that is consistent with community standards, and that the efficient operation of MercyOne will not be disrupted by the practitioner's care of patients within the hospital.
- C. No practitioner shall be entitled to membership on the Medical Staff merely by virtue of the fact that the practitioner is duly licensed to practice in the State of Iowa or any state, or

that the practitioner is a member of any professional organization, or that the practitioner has or has had privileges at any other hospital.

- D. No practitioner will be denied Medical Staff membership or clinical privileges on the basis of race, sex, color, religion, national origin, age or handicap.

Section 3. Inability to Accommodate

Medical Staff membership and the granting of specific privileges may be dependent on the ability of MercyOne to provide adequate facilities and supportive services for the applicant and his/her patients.

Section 4. Provisional Appointments

- A. Members of the Medical Staff will serve in a provisional status that may last up to, but not to exceed two years to allow sufficient time for focused professional practice evaluation. During this provisional period their professional competence and ethical and moral conduct shall be observed by the department chairperson or designee. At the end of the provisional period, the department chairperson will submit a written report to the Credentials Committee indicating whether the practitioner is recommended for full staff status in the appropriate department or whether the provisional period should be extended, indicating a recommended period of time. A practitioner who is not recommended for full staff status and whose provisional period has not been extended shall no longer be a member of the Medical Staff.
- B. During this provisional period the practitioner:
 - 1. may admit patients if their category permits;
 - 2. will serve on at least one departmental or hospital committee as assigned;
 - 3. may not vote or hold office; and
 - 4. are encouraged to attend assigned departmental and general staff meetings.

Section 5. Conditions of Acceptance

- A. By accepting membership on the Medical Staff a practitioner agrees that he or she:
 - 1. will provide patient care in MercyOne in accordance with the clinical privileges granted to the practitioner by the Board;
 - 2. has read these Bylaws and Credentialing and Privileging, Policies and Procedures, and Fair Hearing and Appellate Review manuals and agrees to abide by such Bylaws and manuals, including any subsequent amendments thereto, and any applicable MercyOne policies that may from time to time be put into effect;

3. grants full immunity from liability under the provisions of the Fair Hearing and Appellate Review Manual section of these Bylaws;
4. shall provide for a practitioner with the necessary clinical privileges available to care for the practitioner's patients in MercyOne in the practitioner's absence;
5. if not residing within a reasonable distance from MercyOne as to assume and discharge primary medical responsibilities for patients, shall arrange for a practitioner with the necessary clinical privileges to care for the practitioner's patients in MercyOne in the practitioner's absence;
6. shall not rebate a portion of a fee, or accept inducements in exchange for a patient referral;
7. shall not deceive a patient as to the identity of an operating surgeon or any other practitioner providing treatment or a service to the patient;
8. shall not delegate the responsibility for the diagnosis or care of any patient of MercyOne to any practitioner or other person who is not licensed or professionally qualified to undertake this responsibility;
9. shall continue to maintain in force professional liability insurance in an amount that will not be less than specified by Trinity Health, with the exception that this requirement does not apply to providers who do not have clinical privileges;
10. shall agree to abide by those regulations imposed on the hospital by regulatory agencies and law;
11. has read and agrees to abide by the Ethical and Religious Directives for Catholic Health Care Services;
12. has read and agrees to abide by the Trinity Health Organizational Integrity Program, including the standards of conduct;
13. shall agree to abide by the Notice of Privacy Practices;
14. shall participate in the care of indigent patients; and
15. agrees that at the time of application, initial appointment, reappointment, or at any other time, the Board, acting upon a written request from the Executive Committee, may direct that the practitioner undergo a physical and/or mental evaluation by a physician or licensed psychologist who is not affiliated with MercyOne. This agreement constitutes a waiver of confidentiality to the extent of the procedures set forth in this paragraph. Failure to comply with the Board's request will be grounds for rejection of a pending application for appointment or reappointment to the

Medical Staff, or the immediate summary suspension of a practitioner who has already been accorded Medical Staff Membership. Provisions for fair hearing and appellate review are provided for in the Fair Hearing and Appellate Review Manual, which by reference is incorporated as part of these Bylaws.

The non-affiliated physician selected to perform the evaluation will be mutually acceptable to both the practitioner and the President of the Medical Staff. In the event that such mutual acceptance is not possible, the non-affiliated physician shall be jointly selected by the chairperson of the Board, the Hospital President and the chairperson of the Executive Committee.

MercyOne will pay only the professional fee(s) of the selected non-affiliated physician performing the evaluation, as well as the professional fees or other direct expenses incurred as the result of ancillary examinations or procedures requested or directed for the non-affiliated physician. The report of the non-affiliated physician will be forwarded to the Credentials Committee.

Section 6. Leave of Absence

- A. A member of the Medical Staff may request a Leave of Absence for up to a 12- month period by submitting a written request to the Executive Committee and the Hospital President. If the regularly scheduled reappointment date occurs during that period, the practitioner must follow the reappointment process. A Leave of Absence does not extend the normal two-year appointment cycle. Notification of reappointment will note the practitioner is on a Leave of Absence until a designated date.
- B. When the practitioner returns from a Leave of Absence of any length, copies of current licenses, malpractice insurance, information concerning any legal actions and written documentation of the practitioner's professionally related activities during the Leave of Absence shall be provided to the Office of Medical Staff Services.
- C. It is the practitioner's responsibility to notify the Office of Medical Staff Services when he/she plans to return from a Leave of Absence. Failure to return or obtain an authorized extension by the date of the end of the Leave of Absence shall automatically result in the termination of the practitioner's Medical Staff membership and shall not entitle the practitioner to any type of hearing under the Fair Hearing and Appellate Review Procedures.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff is divided into Honorary, Active, Dental, Associate, and Courtesy categories. Each member of the Medical Staff shall be assigned to a staff category and shall be subject to the responsibilities and prerogatives of that category as defined in these Bylaws and the Policies and Procedures Manual which by reference is incorporated as part of these Bylaws.

Section 2. Honorary Medical Staff

- A. Honorary Medical Staff consists of those retired practitioners who have practiced at MercyOne for 15 or more years but are not currently active in MercyOne. A request for Honorary Staff status shall be submitted to the President of the Medical Staff in writing.
- B. Members of the Honorary Staff:
 - 1. do not have admitting and clinical privileges;
 - 2. are not required to pay staff dues;
 - 3. are not eligible to hold elected Medical Staff office, or to be assigned to Medical Staff committees;
 - 4. cannot vote on Medical Staff affairs; and
 - 5. may attend educational conferences and programs at MercyOne.

Section 3. Active Medical Staff

- A. The Active Medical Staff consists of physicians who reside in the community or practice within a reasonable driving distance of MercyOne (with the exception of telemedicine providers) and who are capable and willing to assume all functions of the Active Medical Staff.
- B. The members of the Active Medical Staff:
 - 1. may have admitting and clinical privileges if so indicated on the individual's Delineation of Privileges form and approved by the Board;
 - 2. are assessed staff dues;
 - 3. are eligible for elected medical staff office;
 - 4. are eligible for department chairmanship of their respective department;
 - 5. are required to serve on committees as designated by the President of the Medical Staff;
 - 6. may vote in all medical staff affairs;
 - 7. are encouraged to attend all departmental and regular medical staff meetings.
 - 8. are required to participate in emergency room rotation assignment of unassigned

patients including inpatients as well as care for their patients or patients of physicians for whom they have assumed responsibility who present themselves for care to the emergency room; and

9. shall assume responsibility for a timely history and physical (which may be provided by a qualified licensed physician/practitioner who does not practice at the hospital but is acting within his/her legal scope of practice) and for the care of any medical problems that may be present or arise during hospitalization for the patients of the Dental and Associate Medical Staffs; and
10. may be assigned teaching responsibilities for residents and shall remain accountable for the patients cared for by these residents.
11. may be a telemedicine provider. Physicians who are credentialed to provide telemedicine are not assessed dues and may not vote in medical staff affairs.

Section 4. Dental Staff

- A. The Dental Staff consists of those dentists and oral surgeons who are licensed to provide dental services.
- B. Members of the Dental Staff:
 1. who are dentists may initiate the process for admitting a patient after an appropriate physician member of the Active Medical Staff or a qualified licensed physician/practitioner who does not practice at the hospital but is acting within his/her scope of practice under State law or regulations has agreed to perform a timely history and physical, and the completed history and physical is reviewed by the dentist performing the procedure prior to the patient's surgery;
 2. who are qualified Oral Surgeons may admit patients for oral surgery, may perform the entire history and physical examination on those patients if they have such privileges, and may assess the medical risks of the proposed surgical procedure(s);
 3. responsible for and shall record that portion of the patient's history and physical examination related to dentistry;
 4. are assessed staff dues;
 5. are eligible for elected medical staff office;
 6. are required to serve on committees as designated by the President of the Medical Staff;
 7. may vote in all medical staff affairs;

8. are encouraged to attend all departmental and regular medical staff meetings; and
9. are required to participate in emergency room rotational assignment of unassigned patients as well as care for their patients or patients of dentists for whom they have assumed responsibility who present themselves for care to the emergency room.

Section 5. Associate Medical Staff

A. The Associate Medical Staff consists of podiatrists and psychologists.

1. Associate Staff Psychologist means a practitioner who possesses a doctoral degree in psychology from a regionally accredited university and a current Iowa license issued by the Iowa State Board of Psychology Examiners. Such practitioners must have had at least one (1) year supervised practical experience in an accredited hospital providing inpatient mental health services and must be a member of the National Register of Health Services Providers in Psychology.
2. Podiatrist means a practitioner who possesses a current license to practice podiatry from the State of Iowa.

B. Members of the Associate Medical Staff:

1. may initiate the process for admitting a patient after an appropriate physician member of the Active Medical Staff has agreed to perform a timely history and physical and to care for any medical problems that may be present or arise during hospitalization;
2. are responsible for and shall record that portion of the patient's history and physical examination related to their specialty;
3. exercise limited clinical privileges as delineated and granted;
4. are assessed Medical Staff dues;
5. may not hold Medical Staff office;
6. may serve as departmental chairperson or vice-chairperson of their respective department if the other position is held by a physician;
7. may vote in all medical staff affairs;
8. are required to serve on committees as designated by the President of the Medical Staff;
9. may attend educational conferences and programs at MercyOne; and

10. are encouraged to attend all departmental and regular medical staff meetings.

Section 6. Courtesy Medical Staff

A. The Courtesy Medical Staff shall consist of physicians and dentists otherwise qualified for Staff membership who:

1. normally admit their patients to another facility;
2. wish to limit their activity to an annual total of 20 patients, including consultations and admissions for inpatient care, observation, or outpatient procedures;
3. wish to provide limited medical services such as history and physical examinations for their patients referred to specialists at MercyOne; or
4. wish to order special tests or refer patients to MercyOne for special procedures, as delineated and granted.

B. Members of the Courtesy Medical Staff:

1. may apply for admitting privileges to care for less than 20 patients per year within the limits of their assigned clinical privileges;
2. are required to retain responsibility within their area of professional competence for the care and supervision of each patient in the hospital for whom they are providing services or arrange for a suitable alternative for such care and supervision;
3. shall be assigned to a specific department;
4. are not assessed Medical Staff dues;
5. are not eligible for elective Medical Staff office;
6. have no vote in Medical Staff affairs;
7. are not obligated to attend Medical Staff meetings;
8. may attend educational conferences and programs at MercyOne; and
9. are required to go through routine reappointment.

Section 7. Salaried (Medical-Administrative) Staff and/or Contract Practitioners

A. Salaried and/or contract practitioners must qualify for and maintain medical staff membership and privileges in the same manner prescribed for Active members of the

Medical Staff. Membership on the Medical Staff may be made contingent on continuing in a medical/administrative position. Any practitioner whose engagement by MercyOne requires membership on the Medical Staff as described above shall not have his/her medical privileges terminated without the same fair hearing provisions as must be provided for any other member of the Medical Staff, unless otherwise stated in the contract.

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

All applications for appointment to the Medical Staff or Allied Health category shall be in writing, shall be completed and signed by the applicant, and shall be submitted on a form prescribed by the Credentials Committee. (Additional details and procedures for initial appointment to the Medical Staff and reappointment to the Medical Staff are outlined in the Credentials Manual which is included as an Article of these Bylaws and which may be amended by the Executive Committee.)

ARTICLE VI: OFFICERS

Section 1. Officers of the Medical Staff

- A. Officers of the Medical Staff shall provide effective governance of its affairs so as to ensure proper acceptance and discharge of the overall responsibility for the medical care delegated to the Medical Staff by the Board.

The officers of the Medical Staff shall be:

1. President
2. President-Elect
3. Immediate Past President
4. Secretary-Treasurer

Section 2. Qualifications of Officers

- A. Officers must be members of the Active Medical/Dental 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. Officers shall be chosen on the basis of ability and commitment. The president of the staff must be an M.D. or D.O.

Section 3. Election of Officers

- A. Officers shall be elected at the annual meeting of the Medical Staff subject to Board approval. Only members of the Medical Staff shall be eligible to vote. Voting may be by a show of hands unless more than one has been nominated for a specific office. In such case, written ballot must be utilized. When more than two nominees are slated and one does not

receive a majority vote, the candidate receiving the least number of votes will be omitted from each successive balloting until a majority vote is received by one candidate.

The Nominating Committee shall consist of the President of the Medical Staff, the Hospital President and selected representative from the Medical Staff Executive Committee who are currently on the Active Medical Staff.

- B. The Nominating Committee shall meet at least thirty (30) days prior to the annual meeting of the Medical Staff to recommend a slate of nominees for the election of officers for the ensuing Medical Staff year.
- C. Nominations may also be made from the floor by any member of the Medical Staff at the time of the annual meeting.

Section 4. Term of Office

All officers shall serve a two (2) year term from their election date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year, or January 1.

Section 5. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the presidency, shall be elected by the Executive Committee of the Medical Staff. If there is a vacancy in the office of the President, the President-elect shall serve out the remaining term.

Section 6. Duties of Officers

A. President

The President shall serve as Chief Administrative Officer of the Medical Staff to:

1. coordinate and cooperate with the Hospital President of MercyOne in all matters of mutual concern;
2. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
3. serve as chairperson of the Medical Staff Executive Committee;
4. serve as ex-officio member of all other Medical Staff committees without vote;
5. be responsible for the enforcement of the Medical Staff Bylaws, Policies and Procedures, for the implementation of sanctions where these are authorized by the Board, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

6. appoint, in consultation with the Hospital President of MercyOne, members to all standing and special Medical Staff committees, which may be multi-disciplinary, except the Executive Committee;
7. represent the views, policies, needs and grievances of the Medical Staff to the Hospital President and when appropriate, through the Hospital President to the Board;
8. receive and interpret the policies of the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
9. be the spokesperson for the Medical Staff in its external professional and public relations;
10. participate in medical staff leadership activities sponsored by Trinity Health; and
11. serve as an ex-officio member of the Board without vote.

B. President-Elect

The President-Elect shall:

1. assume all duties and have all authority in the absence of the President;
2. succeed the President when he/she is unable to serve for any reason;
3. serve as a member of the Executive Committee;
4. perform such other duties as assigned by the President or the Executive Committee; and
5. may serve as a member of the MercyOne Joint Quality Oversight Committee.

C. Immediate Past-President

The Immediate Past-President shall:

1. serve as a member of the Executive Committee; and
2. serve as a member of the Nominating Committee and other committees to which appointed.

D. Secretary-Treasurer

The Secretary-Treasurer shall:

1. keep, or cause to be kept, accurate and complete minutes of all Medical Staff meetings;
2. call Medical Staff meetings on order of the President;
3. attend to all correspondence;
4. account for all funds of the Medical Staff including obtaining an annual audit by the Chief Financial Officer of MercyOne;
5. serve as a member of the Executive Committee; and
6. perform such other duties as may be assigned by the President or the Executive Committee.

Section 7. Removal of Officers

- A. Subject to the approval of the Board, an officer may be removed from office for the following reasons:
 1. failure to comply with applicable policies, bylaws, or rules and regulations;
 2. failure to perform the duties of office;
 3. exhibiting conduct detrimental to the interests of MercyOne and/or the Medical Staff;
 4. suffering from an infirmity that renders the individual incapable of fulfilling the duties of office.
- B. Removal of an officer requires a two-thirds (2/3) vote of the Medical Staff Executive Committee members in attendance at a meeting in which a quorum is present, or by a two-thirds (2/3) vote of voting members of the Medical Staff in attendance at a meeting in which a quorum is present.

ARTICLE VII. CLINICAL DEPARTMENTS

Section 1. Departments

The Medical Staff shall be divided into the following departments:

- A. Anesthesia
- B. Psychiatry

- C. Emergency Medicine
- D. Medicine
- E. Obstetrics & Gynecology
- F. Oral Surgery and Dentistry
- G. Pathology
- H. Pediatrics and Newborn
- I. Radiology
- J. Surgery

Section 2. Organization of Clinical Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a chairperson who shall be responsible for the overall supervision of the departmental functions.

Section 3. Qualifications, Selection and Tenure of Department Chairperson and Vice-Chairpersons

- A. Each department shall elect a chairperson and a vice-chairperson at a meeting prior to the annual meeting of the Medical Staff and the last meeting of the calendar year of the Board. The department chairperson and vice-chairperson shall be board certified or affirmatively established to have equivalent qualifications and approved by the Board. An Associate Member may serve as a department chairperson or vice-chairperson if the other position is held by a physician. The department chairperson shall be responsible to the president of the staff for departmental functions.
- B. Each chairperson may be elected for a two (2) year term, subject to approval of the Board, with no limit on the number of terms that can be served. Department chairpersons assume office on the first day of the calendar year.
- C. Removal of the chairperson during term of office may be initiated by a two-thirds majority vote of all Active Staff members of the department, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and by the Board.
- D. The Vice Chairperson shall represent the chairperson in the event that person cannot serve as department chairperson or attend Medical Staff Executive Committee meetings. This person shall be responsible to the president of the Medical Staff for departmental functions and shall have the right to vote on the Executive Committee whenever the department chairperson cannot assume these duties.

Section 4. Functions of Department Chairpersons

Each chairperson shall:

- A. be accountable for all professional and administrative departmental activities;
- B. be a member of the Executive Committee, providing guidance on the overall medical policies of the hospital and making specific departmental recommendations and suggestions in order to identify opportunities to improve care and identify important problems in patient care;
- C. maintain continuous monitoring of the clinical performance of all departmental practitioners with clinical privileges and report regularly thereon to the Executive Committee;
- D. assure the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the department;
- E. be responsible for departmental implementation of actions taken by the Executive Committee;
- F. transmit to the Credentials Committee his or her recommendations concerning criteria for clinical privileges, the staff classification, appointments and reappointments, the delineation of clinical privileges for all dependent and independent departmental practitioners and recommendations for corrective action;
- G. be responsible for departmental orientation, continuing education, teaching, and research programs;
- H. participate in every phase of departmental administration through cooperation with nursing service and hospital administration in matters affecting patient care, including space, personnel, supplies, special regulations, standing orders and techniques; and assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization;
- I. develop and implement policies and procedures that guide and support the provision of care, treatment, and services;
- J. make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- K. maintain quality control programs, as appropriate;
- L. assist in the preparation of departmental annual reports, including budgetary or long-range planning as may be required by the Executive Committee, the Hospital President or the Board;
- M. coordinate services within the department and integrate the department with other departments and with the primary functions of the hospital.

Section 5. Function of Departments

- A. Each clinical department shall establish its own criteria, consistent with the policies of the Medical Staff and of the Board, for the granting of clinical privileges and for holding of office in the department.
- B. Departmental meetings shall be held no less often than twice per year and at the call of the chairperson to review the care and treatment of patients served by the hospital. This should include consideration of selected deaths, unimproved patients, patients with infections or complications, errors in diagnosis and treatment, tissue review reports, resultant unresolved problem cases, and such other reports as are believed to be important, i.e., blood transfusions, and mortality and morbidity rates.
- C. Each clinical department shall establish an executive committee of the department to accomplish quality assurance activities and ongoing peer review in a timely fashion between departmental meetings, the results of which will be presented at the subsequent departmental meeting.
- D. Surgical and/or procedure case review is performed monthly by those departments performing surgical or invasive/targeted non-invasive procedures. Review is conducted for cases whether or not a tissue or non-tissue specimen was removed. All cases in which a major discrepancy exists between pre-operative and post-operative (including pathologic) diagnoses are evaluated with a written report of conclusions, recommendations, actions taken, and the evaluation of actions taken.
- E. The quality of medical records is reviewed at least quarterly for clinical pertinence and timely completion.
- F. The minutes of each departmental meeting shall be submitted to the Executive Committee and the Hospital President.
- G. A quorum shall be the Medical Staff membership of that department present and voting.

Section 6. Assignment to Departments

The Executive Committee shall, after consideration of the recommendation of the Credentials Committee, recommend to the Board initial departmental assignment for all medical staff members and allied health professionals.

ARTICLE VIII: COMMITTEES

All Committees of the Medical Staff are charged with the duty and responsibility of peer review functions, review of professional competence and continuing study for the purpose of reducing morbidity and mortality.

Section 1. General

- A. Committees of the Medical Staff shall be designated as standing or special. Standing committees shall be those committees created in these Bylaws. Special committees shall be those committees that the Executive Committee shall determine to be necessary and appoint. Special committees are identified in the Policies and Procedures Manual which by reference is made part of these Bylaws and which may be amended by the Executive Committee.
- B. Unless otherwise a member of a committee, the President of the staff and the Hospital President shall serve as ex-officio members of all committees of the Medical Staff without vote.
- C. All practitioner committee members are appointed by the President of the staff, with the consent of a majority vote of the Executive Committee. All other committee members are appointed by hospital administration.

Section 2. Term

Unless otherwise specified herein, all committee appointments shall be for the Medical Staff year.

Section 3. Committee Chairperson

Unless otherwise specified herein, the chairperson of each committee shall be a member of the Medical Staff and will be appointed by the President of the staff.

Section 4. Authority and Manner of Acting

- A. All committees of the Medical Staff, except the Executive Committee, are subject to the authority of, and shall report to the Executive Committee.
- B. Unless otherwise provided in these Bylaws or directed, in writing, by the Executive Committee, any committee may recommend any action to the Executive Committee by the vote of a majority of its members present at a meeting where physicians are present and voting.
- C. Committees are authorized to perform such functions as are specified in these Bylaws or the Policies and Procedures Manual or as may be directed by the Executive Committee.
- D. All Committees shall prepare and file minutes of all meetings with the Office of Medical Staff Services.
- E. A quorum shall be 50% of the voting members of standing committees and those present and voting for special committees.

Section 5. Executive Committee

- A. Composition: The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff, the Chairperson of each clinical department, the medical director of the trauma program, and a representative of the hospitalist service. All members of this committee serve by virtue of their office with their term of service being determined by that office. The President of the Medical Staff shall be the Chairperson of the Executive Committee. The Hospital President is an ex-officio member without vote.
- B. Duties: The duties of the Executive Committee shall be:
1. To represent and to act on behalf of the Medical Staff subject to such limitations as may be imposed by these Bylaws;
 2. To coordinate the activities and general policies of the departments of the Medical Staff;
 3. To receive and act upon reports and recommendations from all Medical Staff committees, departments and assigned activity groups;
 4. To implement approved policies of the Medical Staff;
 5. To provide liaison between the Medical Staff, the Hospital President and the Board;
 6. recommend action to the Hospital President on matters of medical/ administrative nature;
 7. To make recommendations on hospital management matters to the Board through the Hospital President
 8. To fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the hospital;
 9. To inform the Medical Staff of actions of The Joint Commission and other regulatory programs including the status of The Joint Commission survey results and the recommendations and requirements of other regulatory bodies;
 10. To review the credentials of all applicants and to make recommendations to the Board for Staff membership, assignments to departments and delineation of clinical privileges.
 11. To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations regarding reappointments and renewal or changes in clinical privileges;
 12. To take all reasonable steps to ensure professionally ethical conduct and competent

clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted; and

13. To determine annually the amount of Medical Staff dues and the appropriate use of these funds.
- C. Meetings: The committee shall meet regularly and maintain a permanent record of its proceedings and actions. All members have the right to vote and, if unable to attend, may send a substitute member of the same department provided such person has voting privileges as a member of the Medical Staff.

Section 6. Medical Staff Bylaws Committee

- A. Composition: This shall be a standing committee composed of the past president and president-elect of the Medical Staff, a representative from each clinical department, a physician representative from the Board, and a representative from Mercy administration. Legal counsel may be invited to act in an advisory capacity.
- B. Duties: This committee shall be responsible for making recommendations relating to revisions to and updating of the Bylaws and Policies and Procedures of the Medical Staff.
- C. This committee shall meet at least annually, shall maintain a record of its proceedings and activities, and shall report annually to the Executive Committee including recommendations for changes to the Bylaws.

Section 7. Credentials Committee

- A. Composition: This shall be a standing committee composed of one Medical Staff member elected from each department and one at-large member appointed by the President of the Medical Staff.
- B. Duties: The duties of the Credentials Committee shall be:
 1. To review the credentials of all applicants for medical staff appointment, reappointment and clinical privileges, to make investigations of and interview such applicants as may be necessary and to make a report of its findings and recommendations through the Executive Committee to the Board;
 2. To review the credentials of all applicants who request to practice at the hospital as allied health professionals, to make investigations of and interview such applicants as may be necessary and to make a report of its findings and recommendations through the Executive Committee to the Board;
 3. To review periodically all information available regarding the competence of staff members and as a result of such review to make recommendations through the

Executive Committee to the Board for the granting of privileges, reduction of privileges, reappointments and the assignment of staff categories;

4. To investigate any breach of ethics reported to it as well as review any comments or questions that arise, and review information available regarding the clinical competence and behavior of persons currently appointed to the medical staff and of those practicing as allied health professionals and, as a result of such review, to make a report of its findings and recommendations;
5. To establish criteria for privileging for new procedures after consultation with the persons involved, the appropriate department chairperson(s) and other interested parties and after thorough evaluation of medical literature information, established guidelines, recommended training and experience and any other information it deems pertinent; and
6. To annually review and recommend amendments to the Credentials Manual.

ARTICLE IX: MEETINGS

Section 1. Annual Meeting

The annual meeting of the Medical Staff shall be held in November, at such time and place as the President of the Medical Staff shall designate. The agenda of the annual meeting will include the election of officers, ratification of department chairpersons and vice-chairpersons who have been elected by their respective departments, and the committee chairpersons and vice-chairpersons appointed by the President of the Medical Staff.

Section 2. Department and Committee Meetings

Department and committee meetings will be held in accordance with the provisions of Article VII and VIII of these Bylaws.

Section 3. Special Meetings

A. Medical Staff Meetings.

1. Special meetings of the Medical Staff may be called at any time at the discretion of the President of the staff or at the request of the Hospital President, the Executive Committee, or the Board. A special meeting will also be called within seven (7) days by the President of the staff upon receipt of a written request stating the purpose of such meeting signed by at least five (5) members of the Active Medical Staff.
2. Written or printed notice stating the place, day and time of any special meeting shall be delivered personally or by mail to each voting member of the Medical Staff at

least five (5) days before the date of such meeting. If mailed, such notice shall be postmarked at least seven (7) days before the date of such meeting. The attendance of a member of the Medical Staff at a special meeting shall constitute a waiver of notice of such meeting.

3. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

B. Department or Committee Meetings:

1. Special meetings of a department or committee may be called at any time at the discretion of the Chairperson, or at the request of the Hospital President, President of the staff, Executive Committee, Board or at the request of not less than forty percent (40%) of the practitioners who are members of such department.
2. Written or oral notice stating the place, day and time of any special meeting of a department or committee shall be given each practitioner who is a member of such department or committee not less than five (5) days before the time of such meeting.
3. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 4. Quorum

- A. Those voting members of the Medical Staff present shall constitute a quorum at any departmental meeting of the Medical Staff in accordance with Article VII, Section 5.G. of these Bylaws.
- B. Quorum requirements for committees are in accordance with Article VIII, Section 4.E. of these Bylaws.
- C. The quorum requirement for regular meetings is the voting members present and special meetings of the Medical Staff is 50% of the voting members.

Section 5. Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members, the vote taken on each matter, and follow-up action required. Copies of all minutes shall be forwarded to the Executive Committee for review. A permanent file of all minutes shall be maintained.

Section 6. Notice

Except for special meetings which have notice requirements as provided in Section 3 of this Article IX, written or oral notice stating the place, day and time of any meeting of the Medical Staff or a department or committee thereof shall be given to voting members of the Medical Staff, or the

practitioner members of a department or committee not less than seven (7) days prior to such meeting by the person or persons calling the meeting. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the practitioner at the practitioner's address as it appears on the records of the hospital. The attendance of a practitioner at a meeting shall constitute a waiver of notice of such meeting.

Section 7. Attendance

- A. Members of the clinical departments are encouraged to attend all regularly scheduled meetings of the department.
- B. A practitioner who has attended a case that is to be presented for discussion at any meeting of a department or committee may be given notice of such meeting and shall be expected to attend such meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall so state and shall include a statement that the practitioner's attendance is mandatory. Failure of the practitioner to attend such meeting may be grounds for corrective action.
- C. Failure by a practitioner to attend any meeting in which the practitioner was notified that attendance was mandatory, unless excused by the Executive Committee for good cause, shall result in an automatic suspension of all or a portion of the practitioner's clinical privileges as the Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action if necessary.
- D. The failure of any practitioner to meet attendance requirements set forth herein shall be grounds for corrective action leading to revocation of Medical Staff membership.

Section 8. Agenda

- A. The agenda for meetings of departments and committees shall be established by the respective Chairperson.
- B. The agenda at special meetings shall be:
 - 1. reading of the notice calling the meeting;
 - 2. transaction of business for which the meeting was called; and
 - 3. adjournment.

Section 9. Conduct of Business in the Meeting

The rules contained in Robert's Rules of Order shall govern all meetings in all cases to which they are applicable and in which they are not inconsistent with MercyOne Medical Staff Bylaws.

**ARTICLE X:
CORRECTIVE ACTION, SUMMARY SUSPENSION AND AUTOMATIC SUSPENSION**

Section 1. Initiation of Corrective Action

- A. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards of the Medical Staff, a possible threat to the well-being of patients in MercyOne, or disruptive to the operations of MercyOne, or where the practitioner has failed to attend a mandatory meeting whose purpose is to discuss an apparent or suspected deviation from standard clinical practice, corrective action may be requested in accordance with paragraph B of this Section 1 by:
1. any officer of the Medical Staff;
 2. the chairperson of any department;
 3. the chairperson of any standing committee of the Medical Staff;
 4. the Hospital President; or
 5. the Chairperson of the Board.
- B. All requests for corrective action shall be made in writing to the Executive Committee and shall make reference to the specific activities or conduct which constitute the grounds for the request.
- C. Upon receipt of a request for corrective action, the President of the Medical Staff will establish an ad hoc committee to investigate the request. The ad hoc committee will be comprised of:
1. the Hospital President;
 2. the department chairperson (or designee) concerned; and
 3. one member of the Active Medical Staff appointed by the President of the Staff.

Section 2. Informal Investigation

- A. Upon their appointment, the ad hoc committee will immediately proceed to investigate, in any manner it deems appropriate under the circumstances, the allegations contained in the request for corrective action. It shall be the purpose of the ad hoc committee to attempt to ascertain the facts surrounding the request for corrective action, and, if possible, to work with the affected practitioner and the person requesting corrective action to informally resolve the problems that have led to the request for corrective action. Prior to making its report, the ad hoc committee will give the affected practitioner the opportunity for an interview to discuss the request for corrective action. The actions of the ad hoc committee

shall be informal in nature, but it shall make a record of all such appearances. The affected practitioner has no right to legal counsel or other representation at this information interview. None of the procedural rules provided in these Bylaws or the appended Fair Hearing and Appellate Review Manual with respect to hearings or appeals shall apply.

- B. Within fourteen days after their appointment, the ad hoc committee will prepare a written report of its investigation and attempts at resolution and make a recommendation to the Executive Committee on what action, if any, should be taken regarding the request for corrective action.

- C. In the event that the ad hoc committee finds that the practitioner's actions are due to impairment of any type and the practitioner agrees to voluntarily temporarily relinquish clinical privileges and undergo appropriate rehabilitation, the committee may hold its report in abeyance pending completion of rehabilitation as outlined in the Board's Impaired Medical Staff Member Policy. If the practitioner discontinues rehabilitation prior to completion of an agreed upon program, the ad hoc committee will make an immediate report to Medical Staff Executive Committee.

- D. The ad hoc committee may recommend any one or more of the following actions regarding the request for corrective action:
 - 1. dismissal on the basis of an informal settlement;
 - 2. rejection;
 - 3. modification;
 - 4. acceptance and the practitioner:
 - a. be issued a warning;
 - b. be given a letter of admonition;
 - c. be formally reprimanded;
 - d. be imposed upon by specific terms of probation;
 - e. be required to undergo consultation or a physical or mental examination; or
 - f. have clinical privileges reduced, suspended or revoked;
 - g. have an already imposed summary suspension of clinical privileges terminated, modified or sustained; or
 - h. have the practitioner's Medical Staff membership suspended or revoked.

- E. The report of the ad hoc committee shall be delivered to the Executive Committee and the Hospital President, and a copy of the report and recommendation of the ad hoc committee will be sent by certified mail, return receipt requested, to the affected practitioner. The affected practitioner shall be advised that he or she has ten days to respond in writing to the Executive Committee regarding the ad hoc committee's report and recommendations.

Section 3. Action on Ad Hoc Committee Recommendations

- A. At the next regularly scheduled meeting of the Executive Committee after the affected practitioner has submitted written comments, or, if no comments have been submitted and the time for filing written comments has expired, the Executive Committee shall review the report and recommendations of the ad hoc committee and the written comments, if any, submitted by the affected practitioner. The Executive Committee shall determine a recommendation to be made to the Board on the request for corrective action and transmit such recommendation to the Board through the Hospital President.
- B. Any action by the Executive Committee to reduce, suspend, or revoke clinical privileges or to suspend or to revoke Medical Staff membership shall confer upon the Medical Staff member the procedural rights set forth in the appropriate section of the Fair Hearing and Appellate Review Manual of these Bylaws.

Section 4. Summary Suspension

- A. Whenever a medical staff member's activities or professional conduct, including any oral or written act, either within or outside of the hospital, are, or are reasonably likely to be, contrary to patient safety or the delivery of quality patient care, disruptive to hospital operations or the continued effective operation of the hospital, the President of the Medical Staff, the Hospital President or the Chairperson of the Board shall have the authority to summarily suspend the medical staff membership status of all or any portion of clinical privileges of such staff members. Any summary suspension imposed shall be effective immediately upon imposition and shall, in the event that corrective action is recommended, continue pending resolution of the request for corrective action, except as otherwise determined by the Hospital President.
- B. When all or a portion of the clinical privileges of a practitioner are suspended in accordance with this section, the Hospital President shall immediately give notice of such action to the affected practitioner by certified mail, return receipt requested, and also give notice to the Executive Committee.
- C. Upon receipt of a notice of summary suspension, the Executive Committee, within twenty-four hours, shall review the action of the Hospital President and decide to either:
 - 1. lift the summary suspension and treat the Hospital President's action as a request for corrective action to be processed in accordance with the provisions of this Article X; or

2. maintain the summary suspension in effect and proceed to process the Hospital President's action as a request for corrective action to be processed in accordance with the provisions of this Article X.
- D. Immediately upon the imposition of a summary suspension, the President of the Staff or chairperson of the department concerned shall have the authority to provide for alternative medical coverage for patients of the suspended practitioner still in MercyOne at the time of suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

Section 5. Automatic Suspension

- A. Any practitioner whose license to practice is revoked or suspended by any agency of the State of Iowa shall automatically have all admitting and clinical privileges at MercyOne suspended. A staff member who has been placed on probation by the Iowa State Board of Medical Examiners may be automatically suspended or his privileges may be retained subject to such conditions as are imposed by the Executive Committee of the Board.
- B. Any practitioner whose DEA registration or Iowa controlled substance license is revoked, suspended, restricted or lapsed shall automatically be divested of the right to prescribe medications covered by such registration/license. As soon as practical after such automatic suspension, the Medical Staff Executive Committee shall convene to review and consider the facts under which the DEA registration or Iowa controlled substance license was revoked, suspended, restricted or lapsed. The Executive Committee shall then take such further action, if any, pursuant to Article X as the Executive Committee determines appropriate.
- C. Any practitioner who fails to complete medical records in a timely manner shall have all admitting and clinical privileges suspended as outlined in the Policies and Procedures Manual.
- D. Any practitioner who fails to attend any committee or service meeting with respect to which the practitioner was given notice that attendance was mandatory shall, unless excused for good cause determined in its sole discretion by the Executive Committee, automatically have suspended all or a portion of the practitioner's clinical privileges as the Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved through any mechanism that the Executive Committee determines to be appropriate under the circumstance.
- E. Any practitioner who fails to renew and/or provide evidence of a current license to practice shall automatically have all admitting and clinical privileges at MercyOne suspended.
- F. Any action taken by any professional liability insurance company to reduce, terminate, or impose conditions on coverage must be promptly reported to the Hospital President. A practitioner's appointment and clinical privileges shall be automatically suspended if the individual's professional liability insurance coverage terminates or lapses or is the subject

of other action causing the coverage to fall below the minimum required by the hospital, or for any other reason ceases to be in effect, in whole or in part. Automatic suspension shall take effect immediately and continue until the matter is resolved.

- G. Any practitioner who is convicted of a felony shall automatically have all admitting and clinical privileges at MercyOne suspended.
- H. In the event of an automatic suspension pursuant to subsection A. of this section, the affected practitioner shall be entitled to the Basic Hearing Procedures found in Article III of the Fair Hearing and Appellate Review Manual which is attached to and by reference included as part of these Bylaws. In the event of an automatic suspension pursuant to subsections B. through H. of this section, the practitioner is entitled only to submit a written statement as outlined in Article I, Section 1.3 of the Fair Hearing and Appellate Review Manual.
- I. A practitioner who fails to abide by hospital policies and procedures regarding signatures, including electronic signatures, or violates any applicable legal requirement regarding the use of electronic signature, shall have electronic signature privileges suspended pending review by the Medical Staff Executive Committee. If a practitioner's medical staff membership or clinical privileges are automatically suspended or terminated, the Medical Staff Office shall notify the practitioner of the suspension or termination in writing, after notifying the Chief of Staff.

ARTICLE XI: IMMUNITY FROM LIABILITY

Section I. Practitioners' Release from Liability

- A. Any practitioner who makes application for appointment or reappointment to the Medical Staff, and each practitioner who is a member of the Medical Staff hereby agrees as follows:
 - 1. To the fullest extent permitted by law, each practitioner releases and gives full immunity from civil liability to all members of the Medical Staff, all representatives, agents and employees of MercyOne, the Board, Quality Assurance and all third parties for all acts, communications, reports, recommendations or disclosures, made in good faith and without malice, performed or made in connection with MercyOne or any other health care institution's activities related to:
 - a. applications for appointment or clinical privileges;
 - b. periodic reappraisals for reappointment or clinical privileges;
 - c. corrective action, including summary suspension;
 - d. hearings and appellate reviews;

- e. medical care evaluations;
 - f. utilization review;
 - g. peer review;
 - h. any department or committee of the Medical Staff; and
 - i. any other activities related to patient care and professional conduct.
2. The acts, communications, reports, recommendations and disclosures referred to in this Article XI may relate to a practitioner's professional qualifications, clinical competency, character, mental or physical well-being, ethics, ability to get along with others, or any other matter that relates directly or indirectly to the practitioner's ability to care for patients in a hospital setting; and
3. The term "third parties" as used in this Article XI means both individuals and organizations, in whatever form, from whom information has been requested relating to the practitioner.
- C. Each practitioner shall, upon the request of the Medical Staff or MercyOne, execute releases in accordance with the provisions of paragraph A above, in favor of the individuals specified therein, subject to the limitation that such releases only apply to acts, communications, reports, recommendations or disclosures made in good faith and without malice.

ARTICLE XII: FAIR HEARING AND APPELLATE REVIEW

A Fair Hearing and Appellate Review Manual is attached and by reference is included as part of these Bylaws. This manual can be amended from time to time by the Executive Committee.

ARTICLE XIII: POLICIES AND PROCEDURES

The Medical Staff shall adopt such Policies and Procedures as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board. These shall relate to the proper conduct of the Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such Policies and Procedures shall be included in a separate attached manual which by reference is made part of these Bylaws. They may be amended or repealed by a two-thirds vote of the Executive Committee at a meeting where a quorum is present subject to the approval of the Board.

ARTICLE XIV: CREDENTIALING MANUAL

A Credentialing Manual is attached and by reference is included as part of these Bylaws. This manual can be amended from time to time by the Executive Committee.

ARTICLE XV: BYLAWS AMENDMENT

Section 1. Procedure for Amendment

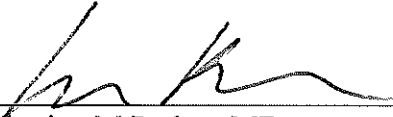
- A. These Bylaws may be amended, in whole or in part, by an affirmative vote of two-thirds (2/3) of the voting Medical Staff present where notice of such proposed amendment has been given in accordance with Article IX of these Bylaws. The Credentialing, Policies and Procedures and Fair Hearing and Appellate Review Manuals can be amended by the Executive Committee at a meeting at which a quorum is present.
- B. Any amendment so adopted shall be subject to, and effective upon, the approval of the Board.
- C. Amendments to these Bylaws are accomplished through a cooperative process involving both the Medical Staff and the Board. Neither party may unilaterally amend these Bylaws.

ARTICLE XVI: ADOPTION

Section 1. Adoption

- A. These Bylaws, when adopted at any regular or special meeting of the Medical Staff, shall be recommended to replace any previous Bylaws.
- B. These Bylaws shall be subject to, and effective upon, approval of the Board. They shall, when adopted and approved, be equally binding on the Board and Medical Staff.

ADOPTED by the Medical Staff of MercyOne on the 1st day of November, 2023.



Katherine M Parker, MD
PRESIDENT OF THE MEDICAL STAFF

Michael S Peroski, DO
SECRETARY OF THE MEDICAL STAFF

APPROVED by the MercyOne Board of Trustees on the 30th day of November, 2023.

Steven J. Domeyer
CHAIRPERSON, BOARD OF TRUSTEES

- e. medical care evaluations;
 - f. utilization review;
 - g. peer review;
 - h. any department or committee of the Medical Staff; and
 - i. any other activities related to patient care and professional conduct.
2. The acts, communications, reports, recommendations and disclosures referred to in this Article XI may relate to a practitioner's professional qualifications, clinical competency, character, mental or physical well-being, ethics, ability to get along with others, or any other matter that relates directly or indirectly to the practitioner's ability to care for patients in a hospital setting; and
 3. The term "third parties" as used in this Article XI means both individuals and organizations, in whatever form, from whom information has been requested relating to the practitioner.
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ARTICLE XIV: CREDENTIALING MANUAL

A Credentialing Manual is attached and by reference is included as part of these Bylaws. This manual can be amended from time to time by the Executive Committee.

ARTICLE XV: BYLAWS AMENDMENT

Section 1. Procedure for Amendment

- A. These Bylaws may be amended, in whole or in part, by an affirmative vote of two-thirds (2/3) of the voting Medical Staff present where notice of such proposed amendment has been given in accordance with Article IX of these Bylaws. The Credentialing, Policies and Procedures and Fair Hearing and Appellate Review Manuals can be amended by the Executive Committee at a meeting at which a quorum is present.
- B. Any amendment so adopted shall be subject to, and effective upon, the approval of the Board.
- C. Amendments to these Bylaws are accomplished through a cooperative process involving both the Medical Staff and the Board. Neither party may unilaterally amend these Bylaws.

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ADOPTED by the Medical Staff of MercyOne on the 1st day of November, 2023.

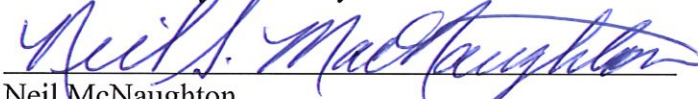


Katherine M Parker, MD
PRESIDENT OF THE MEDICAL STAFF



Michael S Peroski, DO
SECRETARY OF THE MEDICAL STAFF

APPROVED by the MercyOne Board of Trustees on the 30th day of November, 2023.



Neil McNaughton
CHAIRPERSON, BOARD OF TRUSTEES

MERCYONE DUBUQUE MEDICAL CENTER

DUBUQUE, IOWA

CREDENTIALING MANUAL

AND

RELATED DOCUMENTS

ARTICLE XIV OF THE BYLAWS

REVISIONS APPROVED by MercyOne Dubuque Medical Center Medical Staff 2019, 2022,
May-2023, Nov-2023

REVISIONS APPROVED by MercyOne Dubuque Medical Center Board of Trustees 2019, 2022,
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ARTICLE 1: PURPOSE

The Credentialing and Privileging Manual outlines the process and procedures in handling MercyOne's credentialing program. It is the intent of MercyOne to comply with state and federal regulations, including the Healthcare Quality Improvement Act of 1986 as well as standards established by The Joint Commission.

ARTICLE II: APPOINTMENT AND REAPPOINTMENT

Section 1. Initial Application

- A. An individual making initial application for Medical Staff membership shall submit a written application on a prescribed form to the Medical Staff Services Office. By virtue of submitting an application the applicant:
1. accepts the obligation of providing all information requested in support of the applicant's application;
 2. authorizes MercyOne to consult with appointees of medical staffs, hospital administrations, and other professional contacts with whom the applicant has been previously associated; and
 3. consents to the hospital's inspection of all records and documents such as medical school diplomas, state licenses, specialty board certificates and certificates of membership in professional societies and organizations.
- B. The application shall include, at a minimum, the following information:
1. professional education and training;
 2. professional experience;
 3. other professional qualifications, including specialty board membership or active candidate status;
 4. written evidence of current Iowa license, and federal and state DEA (Drug Enforcement Administration) numbers if applicable;
 5. letters of reference from at least three practitioners who are currently knowledgeable about the applicant's professional competence, judgment, and ethical character, preferably at least two from the same specialty;
 6. if applicable, a letter of reference and information to number and type of cases performed from the chief of the clinical service or department of a hospital where the practitioner has or has had clinical privileges;

7. any instance in which the applicant has been subject to legal action based upon an allegation of medical malpractice, including a summary of the allegation, the names of the person or persons making such allegation, and the disposition of the allegation against the practitioner;
8. any instance in which the practitioner's license has ever been suspended or challenged by a state or provincial licensing board in any jurisdiction;
9. whether the applicant has ever been refused admission, renewal or suffered a revocation, suspension, or reduction of staff privileges at any other institution;
10. a specific request for particular staff assignments and delineated clinical privileges;
11. certification that the amount of professional liability insurance maintained in force by the applicant is equal to or greater than the minimal amount required by Mercy Health Services;
12. information relating to the applicant's current physical and mental health, including information relative to communicable diseases;
13. any history of alcohol or drug abuse;
14. agreement to abide by the Ethical and Religious Directives for Catholic Health Care Services;
15. agreement to abide by the Notice of Privacy Practices;
16. agreement to provide for the continuous care of the applicant's patients while they are undergoing treatment at MercyOne;
17. acknowledgment of the immunity from liability provisions of Article XI of these Bylaws;
18. agreement to abide by those regulations imposed on the hospital by regulatory agencies and law; and

Section 2. Action on Initial Appointment

- A. Upon receipt of an application for Medical Staff membership and clinical privileges, the office of Medical Staff Services shall review the application for completeness. An incomplete application shall be returned to the applicant for completion and resubmission. Upon determining that an application is complete, the office of Medical Staff Services shall transmit the completed application to the chairperson of each major clinical department in which the applicant seeks clinical privileges. No applicant will be appointed to the medical staff or granted specific clinical privileges unless the applicant's credentials file contains verified information and supporting data demonstrating current clinical competence. The

chairperson of the clinical department shall forward recommendations to the Credentials Committee.

- B. Upon receipt of a completed application, the Credentials Committee shall expeditiously proceed to:
 - 1. review and investigate the character, health, qualifications and professional competence of the applicant;
 - 2. verify the accuracy of the information contained in the application;
 - 3. request a written opinion from the chairperson of each major clinical department in which the applicant is seeking clinical privileges indicating whether the applicant should be granted the clinical privileges requested, and the scope of the privileges to be granted.
- C. Unless the applicant consents to a longer period of time, within one hundred and twenty (120) days of receipt of the completed application the Credentials Committee shall make a written report of its review to the Executive Committee. Such report shall include a recommendation that the applicant be:
 - 1. appointed to the Medical Staff;
 - 2. be deferred for further consideration; or
 - 3. rejected for Medical Staff membership.

The recommendation of the Credentials Committee shall include specific recommendations for delineating the applicant's clinical privileges.

Section 3. Executive Committee Action on Initial Appointment

- A. At the next regular Executive Committee meeting after the Credentials Committee forwards its report, the Executive Committee will consider the report of the Credentials Committee and determine the recommendation to be made to the Board.
- B. If the recommendation of the Executive Committee is that the applicant should be appointed to the Medical Staff, the Executive Committee shall also specifically recommend the clinical privileges to be granted, including any limitations to be imposed upon such clinical privileges.
- C. If the recommendation of the Executive Committee is to defer action on the application for further consideration, the Executive Committee must specify the specific procedures and time limits that will be used to make a subsequent recommendation on the applicant's acceptance, rejection, or limitation of privileges.

- D. If the Executive Committee's recommendation is that the applicant should be rejected for Medical Staff membership, or that the clinical should be less than requested by the applicant, the Hospital President shall promptly notify the applicant by certified mail, return receipt requested, of the Executive Committee's recommendation. No such adverse recommendation shall be transmitted to the Board until the applicant has exercised or has been deemed to waive rights of appeal pursuant to Article X of these Bylaws.

Section 4. Action of the Board on Initial Application

- A. If the application in question is not subject to an appeal pursuant to Article X of these Bylaws, at the next regularly scheduled meeting of the Board after the Executive Committee has forwarded its recommendation, the Board shall act upon the application. Members of the Medical Staff will serve in a provisional status that may last up to, but not to exceed two years to allow sufficient time for focused professional practice evaluation. During this provisional period their professional competence and ethical and moral conduct shall be observed by the department chairperson or designee. At the end of the provisional period, the department chairperson will submit a written report to the Credentials Committee indicating whether the practitioner is recommended for full staff status in the appropriate department or whether the provisional period should be extended, indicating a recommended period of time. If the decision of the Board is contrary to the recommendation of the Executive Committee, the Board shall submit the matter to a Special Committee appointed by the chairperson of the Board as provided in Section 2, Article X of the Board's Bylaws, for its review and recommendation and shall consider such recommendation before making its final decision.
- B. If the recommendation of the Executive Committee has been appealed pursuant to Article X of these Bylaws, but the applicant has not requested appellate review by the Board of the Hearing Committee's decision, at the next regularly scheduled meeting of the Board after the Hearing Committee has forwarded its decision, the Board will consider the Hearing Committee's decision and the recommendation of the Executive Committee and act upon the application. If the decision of the Board is contrary to the original recommendation of the Executive Committee, the Board shall submit the matter to the Special Committee referred to in Section 4(A) above for its review and recommendations and shall consider such recommendations before making its final decision.
- C. If the recommendation of the Executive Committee has been appealed pursuant to Article X of these Bylaws, and the applicant has requested appellate review of the Hearing Committee's decision by the Board, the decision of the Board on appellate review pursuant to Article X of these Bylaws shall be the Board's action on the initial application.
- D. When the Board's decision is final, it shall send notice of such decision through the Hospital President to the chairperson of the Executive Committee, the chief of any departments wherein the practitioner has been granted clinical privileges, and by certified mail, return receipt requested, to the applicant. If the Executive Committee's recommendation was favorable to the practitioner, and the Board's decision is adverse to the practitioner, such notice will include a right of appeal in accordance with Article X of these Bylaws.

Section 5. Term of Appointment

- A. The Board will make all appointments to the Medical Staff. The initial appointment will be made for a provisional period as defined in Section 4. Thereafter, the member will be subject to reappointment as set forth in Section 6.
- B. Notwithstanding the provisions of this Section 5, the clinical privileges and Medical Staff membership of any practitioner may be suspended or revoked at any time pursuant to Article X of these Bylaws, and the applicable provisions of the governing documents of MercyOne.

Section 6. Reappraisal and Reappointment

- A. Reappointments by the Board shall be for two years, based upon a recommendation of the Executive Committee.
- B. At least ninety (90) days prior to the expiration of reappointment, the Credentials Committee shall begin review of all pertinent information available on each member whose term expires for the purpose of making a recommendation to the Executive Committee on the member's reappointment and for granting of clinical privileges during the term of such reappointment.
- C. The Credentials Committee will initiate its review by requesting, in writing, at least the following information from the member:
 - 1. any change from the information provided by the member in the initial application;
 - 2. any change in the privileges requested by the member;
 - 3. the basis for any request for a change in privileges;
 - 4. the extent of the member's continuing education efforts, as required by law, since the last appointment or reappointment;
 - 5. the practitioner's malpractice insurance coverage; and
 - 6. information relating to the applicant's current physical and mental health, including information relative to communicable diseases.
- D. Simultaneously, the Credentials Committee will obtain, at a minimum, the following information from each department chairperson in each department in which the member has such privileges:
 - 1. the results of ongoing professional practice evaluation;

2. a peer evaluation of the member's performance, judgment, and, when appropriate, technical skill;
3. whether the member has any physical or mental impairments that interfere with the member's ability to care for patients in MercyOne;
4. the member's service on Hospital and Medical Staff committees when requested;
5. whether the member maintains timely, accurate and complete medical records;
6. the member's patterns of care, as demonstrated by reviews and evaluations conducted by committees (such as utilization review, infection control, etc.);
7. the member's ability to work with other members of the Medical Staff and with MercyOne personnel;
8. quality assurance and risk management information; and
9. documentation that the member has entered at least 50% of all orders electronically or, if not, evidence that the member has completed additional training in the use of the electronic medical record.

E. The Credentials Committee shall transmit its recommendation in writing to the Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff shall make written recommendations to the Board concerning the reappointment, nonreappointment, and/or revision of clinical privileges of each practitioner then scheduled for periodic appraisal. In each step above when nonreappointment or a change in the clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

F. Changes in staff category and advances in clinical privileges at reappointment time are for a provisional period as with initial appointment and privilege delineation. As with initial appointment, decisions at reappointment are divided by:

1. medical staff category;
2. departmental assignment; and
3. assignment of specific clinical privileges.

The procedure provided in this Article relating to the recommendations on applications for initial appointment shall be followed.

ARTICLE III: CLINICAL PRIVILEGES

Section 1. Limitation of Clinical Privileges

- A. Every Medical Staff member permitted by law and by MercyOne to provide patient care services independently in the hospital shall have delineated clinical privileges specifically granted by the Board.
- B. Privileges granted to members of the Medical Staff shall be based on their training, experience, and demonstrated competence. The scope and extent of procedures shall be specifically delineated.
- C. A physician member of the Active Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or present itself during the period of hospitalization.

Section 2. Delineation of Clinical Privileges

- A. All clinical privileges granted to practitioners shall be delineated with sufficient specificity to insure that a practitioner does not treat a patient in MercyOne outside the practitioner's area of demonstrated competence.
- B. Podiatrists are recommended for privileges by the chairperson of the Department of Surgery and are under the overall supervision of that chairperson.
- C. Psychologists are recommended for privileges by the chairperson of the Department of Psychiatry and are under the overall supervision of that chairperson. If a psychologist's primary practice is anticipated to be in a department other than Psychiatry, the psychologist may request transfer to that department.

Section 3. Determination of Privileges

- A. Each practitioner shall have the responsibility of establishing his or her qualifications and competency for the clinical privileges requested.
- B. Determination of initial privileges is based upon the applicant's education, training, experience, demonstrated current competence, references, current physical and mental health, and any other relevant information.
- C. Determination of the retention or extension of clinical privileges to members of the Medical Staff is based upon the member's education, training, experience, demonstrated current competence, continuing education effort, current physical and mental health, the observations of the Medical Staff, and any other relevant information.
- D. Granting of clinical privileges shall be for a period of two years.

Section 4. Temporary Privileges

- A. Upon receipt of any application for Medical Staff membership from an appropriately licensed practitioner, and for the period of time required to process the application, but not

to exceed one hundred and twenty days (120), the Hospital President, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the department chairperson concerned and the chairperson of the Executive Committee, may grant temporary privileges to the applicant. In exercising such privileges, the applicant shall act under the supervision of the chairperson of the assigned department or to the department chairperson's designee.

B. Temporary clinical privileges may be granted by the Hospital President upon the recommendation of the department chairperson and the president of the medical staff when an important patient care need requires immediate authorization to practice for a limited period of time while the practitioner's full credentials are verified. Temporary clinical privileges may be granted at reappointment only after the important patient care need that supports such a decision has been documented. An important patient care need includes the following:

1. A circumstance in which one or more patients experience care that does not adequately meet their needs if the hospital does not grant the temporary privileges under consideration.
2. A circumstance in which the hospital risks not adequately meeting the needs of patients if it does not grant the temporary privileges under consideration.
3. A circumstance in which a group of patients in the community face the risk of not receiving care they need if the hospital does not grant the temporary privileges under consideration.

The practitioner under consideration for temporary privileges shall provide signed acknowledgement of having received and read copies of the Medical Staff's Bylaws, Rules and Regulations and agreeing to be bound by the terms thereof in all matters relating to temporary clinical privileges. Such privileges shall be restricted to the period of time when the important patient care need exists, after which such practitioner shall be required to apply for staff membership on the Medical Staff before being allowed to attend additional patients.

C. Locum tenens may be granted by the Hospital President to an appropriately licensed practitioner at the request of a member of the Medical Staff. A practitioner receiving locum tenens may attend patients without applying for membership on the Medical Staff for a period not to exceed one hundred and twenty (120) days, providing all credentials have first been approved by the department chairperson concerned and by the chairperson of the Executive Committee.

D. Special requirements of supervision and reporting may be imposed by the department chairperson concerned regarding any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Hospital President upon

notice of any failure by the practitioner to comply with such special conditions.

- E. The Hospital President, at any time, upon the recommendation of the chairperson of either the Executive Committee or the department concerned, may terminate a practitioner's temporary privileges effective as of the discharge from the hospital of the practitioner's patient(s) being cared for in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 1 of Article X of these Bylaws, and the same shall be immediately effective. The appropriate department chairperson, or if absent, the chairperson of the Executive Committee shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of a substitute practitioner.

Section 5. Telemedicine

Telemedicine services comply with standards published by regulatory bodies including The Joint Commission, CMS, and the Iowa Board of Medicine.

The medical staffs at both the originating (the site where the patient is located at the time service is provided) and distant sites (the site where the practitioner providing the professional service is located) recommend the clinical services to be provided by licensed independent practitioners through a telemedicine link at their respective sites.

- A. Originating Site (MercyOne) retains responsibility for overseeing the safety and quality of services offered to its patients.
 - 1. Credential and privilege all licensed independent practitioners who are responsible for the patient's care, treatment, and services via telemedicine link at the originating site through either of the following mechanisms:
 - a. The originating site fully privileges and credentials the practitioner.
 - b. The originating site privileges practitioners through proxy credentialing using credentialing information from the distant site as specified in contract if the distant site is a Joint Commission-accredited organization.
- B. Distant Site (the site where the practitioner providing the professional service is located).
 - 1. Medical Staff, through the MSEC, recommends which clinical services the LIPs appropriately deliver via telemedicine.
 - 2. Telemedicine clinical services are consistent with the quality standards of the Medical Center.

Section 6. Emergency Privileges

- A. For the purpose of this section, a "clinical emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- B. In the case of a clinical emergency, any practitioner, to the degree permitted by the practitioner's license, shall be permitted and assisted to do everything possible to treat a patient, using any necessary facilities of MercyOne and including the calling of any consultation necessary or desirable.
- C. When a clinical emergency situation no longer exists, the practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.
- D. During disasters in which the emergency operations plan has been activated and the hospital incident commander (hospital president) has determined that immediate patient needs cannot be met, the HIC has the option to grant emergency privileges to volunteer licensed independent practitioners in collaboration with the president of the medical staff or their designee. The "Temporary Disaster Privileges Request Form" will be initiated along with obtaining copies of a valid government-issued photo ID card and at least one of the following:
 - 1. a current photo hospital ID card;
 - 2. a current license to practice;
 - 3. identification indicating that the individual is a member of a Disaster Medical Assistance Team;
 - 4. identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;
 - 5. presentation by current hospital or medical staff members with personal knowledge regarding the practitioner's identity.

Verification of the practitioner's information should be done by the Medical Staff Office within 72 hours. The clinical performance of individuals granted emergency privileges during a disaster in which the emergency operations plan has been activated will be monitored through mentoring by a member of the Active Medical Staff and by medical record review. Based on the results of this monitoring, the hospital will determine within 72 hours of the practitioner's arrival whether the emergency privileges that have been granted should continue. Such privileges shall automatically expire when the hospital

determines the disaster is over. The hospital incident commander (or hospital president) may revoke someone's emergency privileges at any time.

Section 7. Medical Residents

Medical Residents who are enrolled in an approved medical or osteopathic residency may apply for privileges if they:

- A. are licensed in the State of Iowa;
- B. complete an application for privileges as required for locum tenens physicians;
- C. are sponsored by an active staff member;
- D. agree to be directly supervised by that staff member or his or her designee; and
- E. agree to exercise only those specific privileges authorized for their experience level.

Section 8. Medical Students

Students enrolled in a medical or osteopathic school or nurse practitioner or physician assistant accredited program may function under limited circumstances if:

- A. a written application from an active staff member is submitted outlining the specific requested responsibilities;
- B. the request is approved by the appropriate chairperson; and
- C. the sponsoring physician or designee is physically present when the student performs his or her responsibilities.

Section 9. New or Newly Learned Technical Procedures

Each medical staff member requesting new privileges for procedures will be considered on an individual basis by the appropriate department chairperson. The review process will be the same for appointment and reappointment following these parameters:

- A. A formal fellowship, or residency training in the related field with certification by that training program's director, will be the standard for granting specific privileges.
- B. An alternative to this will allow privileging by the completion of an approved educational course in the procedure which will include an understanding of the physiology, anatomy and pathology as well as indications, contraindications and possible complications of the procedure and the appropriate handling of the complications. This should include practical experience in the procedure and a letter of certification by the approved facility which states that the practitioner has received instructions and has shown competence in performing the procedure.

- C. A minimal experience in performing the procedure prior to obtaining privileges at MercyOne must be demonstrated. The number of cases should include those observed, as well as those performed under supervision or independently prior to obtaining the privileges requested. This number will be established independently by the appropriate department for each procedure as requested.
- D. Members of the medical staff who have been granted new privileges will be subject to focused professional practice evaluation in accordance with established criteria and methods.

Section 10. Specific Procedural Privileging Guidelines

- A. Specific guidelines for special procedures such as endoscopy, laser procedures, PCTA, athrectomy, stents, imaging, etc., are included in Appendix A.
- B.
- C. Generic privilege lists are included in Appendix B.

ARTICLE IV: ALLIED HEALTH PROFESSIONALS/MEDICAL STAFF ASSISTANTS

Section 1: General

- A. An Allied Health Professional is an individual who possesses a license, certificate or other legal credential required by Iowa law qualified to provide patient care services in a hospital setting, as approved by the Board.
- B. Medical Staff Assistants are individuals who are qualified by academic or special training to function in a Medical Staff directed role. They do not possess a license, certificate or other legal document required by Iowa law.
- C. Allied Health Professionals and Medical Staff Assistants are not members of the Medical Staff and are not eligible for admitting privileges, with the specific exception of Psychiatric Nurse Practitioners, who are eligible for admitting and discharge privileges, Hospitalist Nurse Practitioners, who are eligible for admitting and discharge privileges on the Acute and Rehab/Skilled units, and Neonatal Nurse Practitioners, who are eligible for admitting and discharge privileges on the Neonatal Intensive Care and Newborn Nursery units.
- D. Allied Health Professionals and Medical Staff Assistants may apply for specific privileges commensurate with documented license, certification, other legal credentials, training and experience.
- E. Allied Health Professionals and Medical Staff Assistants must:
 - 1. provide patients with care at the generally recognized professional level of quality and efficiency;

2. abide by the relevant sections of the Medical Staff Bylaws and by all other lawful standards, policies and rules of MercyOne;
3. discharge such staff, department, committee and hospital functions for which s(he) is responsible by staff category assignment, appointment, election or otherwise;
4. prepare and complete in a timely fashion any documentation relevant to patient care provided;
5. abide by the ethical and moral principles of the relevant profession;
6. read and agree to abide by the Ethical and Religious Directives for Catholic Health Care Services.

F. Allied Health Professionals and Medical Staff Assistants:

1. may provide specified patient care services under the sponsorship, supervision and direction of a member of the MercyOne Medical Staff; with the specific exception that Psychiatric, and Neonatal Nurse Practitioners may do so without such supervision and direction of a member of the MercyOne Medical Staff;
2. the Allied Health Professional may write or enter computerized orders, but not beyond the scope of the Allied Health Professional's license or certificate;
3. shall serve on staff, department and hospital committees as requested;
4. shall attend meetings of committee/departments as requested;
5. may exercise such other prerogatives as shall be, by resolution or written policy, duly adopted by any Medical Staff departments or committees and approved by the Medical Staff Executive Committee and the Board accorded to Allied Health Professionals.

Section 2. Appointment and Reappointment

- A. An Allied Health Professional and Medical Staff Assistant making initial application shall submit a written application on a prescribed form to the Medical Staff Services Office.
1. The applicant accepts the obligation of providing all information requested in support of the applicant's application.
 2. The applicant authorizes MercyOne to consult with appointees of medical staffs, hospital administrations, and other professional contacts with whom the applicant has been previously associated.

3. The applicant consents to the hospital's inspection of all records and documents such as school diplomas, state licenses, and certificates of membership in professional societies and organizations.

B. The application shall include, at a minimum, the following information:

1. professional education and training;
2. professional experience;
3. other professional qualifications;
4. written evidence of current Iowa license, certificate or other legal credentials required by Iowa law;
5. letters of reference from at least three practitioners who are currently knowledgeable about the applicant's professional competence and ethical character, preferably at least two from the same specialty;
6. any instance in which the applicant has been subject to legal action based upon an allegation of medical malpractice, including a summary of the allegation, the names of the person or persons making such allegation, and the disposition of the allegation against the Allied Health Professional or Medical Staff Assistant;
7. any instance in which the Allied Health Professional's license, certificate or other legal credential has ever been suspended or challenged by a state licensing board in any jurisdiction;
8. whether the applicant has ever been refused admission, renewal or suffered a revocation, suspension, or reduction of practice privileges at any other institution;
9. a specific request for particular hospital assignments and delineated practice privileges;
10. certification that the amount of professional liability insurance maintained in force by the applicant is equal to or greater than the minimal amount required by Trinity Health (employed provider may fall under the MercyOne liability insurance policy);
11. information relating to the applicant's current physical and mental health, including information relative to communicable diseases;
12. agreement to observe all of the profession's ethical principles;
13. agreement to observe and abide by the Ethical and Religious Directives of Catholic Health Care Services

14. agreement to abide by the Notice of Privacy Practices;
15. acknowledgment of the immunity from liability provisions of Article XI of these Bylaws;
16. agreement to abide by those regulations imposed on the hospital by regulatory agencies and law; and
17. evidence of completion of training in the use of the electronic medical record.

Section 3. Action on Initial Appointment

- A. Upon receipt of an application from an Allied Health Professional or Medical Staff Assistant, the Office of Medical Staff Services shall review the application for completeness. An incomplete application shall be returned to the applicant for completion and resubmission. Upon determining that an application is complete, the Office of Medical Staff Services shall transmit the completed application to the chairperson of the appropriate clinical department in which the applicant seeks practice privileges. The chairperson of the clinical department shall forward recommendations to the Credentials Committee. In the case of advanced practice nurses, the chairperson shall forward recommendations to the Vice President of Patient Care Services/Chief Nursing Officer for review. The application will then be forwarded to the Credentials Committee.
- B. Upon receipt of a completed application, the Credentials Committee shall expeditiously proceed to:
 1. review and investigate the character, health, qualifications and professional competence of the applicant;
 2. verify the accuracy of the information contained in the application; and
 3. request a written opinion from the chairperson of the appropriate clinical department in which the applicant is seeking practice privileges indicating whether the applicant should be granted the practice privileges requested, and the scope of the practice privileges to be granted.
- C. Unless the applicant consents to a longer period of time, within one hundred and twenty (120) days of receipt of the completed application the Credentials Committee shall make a written report of its review to the Executive Committee. Such report shall include a recommendation that the applicant be:
 1. appointed as an Allied Health Professional or Medical Staff Assistant;
 2. deferred for further consideration; or

3. rejected as an Allied Health Professional or Medical Staff Assistant.

The recommendation of the Credentials Committee shall include specific recommendations for delineating the applicant's practice privileges.

Section 4. Executive Committee Action on Initial Appointment

- A. At the next regular Executive Committee meeting after the Credentials Committee forwards its report to the Executive Committee, the Executive Committee will consider the report of the Credentials Committee and determine the recommendation to be made to the Board.
- B. If the recommendation of the Executive Committee is that the applicant should be appointed, the Executive Committee shall also specifically recommend the practice privileges to be granted, including any limitations to be imposed upon such practice privileges.
- C. If the recommendation of the Executive Committee is to defer action on the application for further consideration, the Executive Committee must specify the specific procedures and time limits that will be used to make a subsequent recommendation on the applicant's acceptance, rejection, or limitation of practice privileges.
- D. If the Executive Committee's recommendation is that the applicant should be rejected or that the practice privileges granted to the applicant should be less than requested by the applicant, the Hospital President shall promptly notify the applicant by certified mail, return receipt requested, of the Executive Committee's recommendation. No such adverse recommendation shall be transmitted to the Board until the applicant has exercised or has been deemed to waive his or her rights for departmental review under Article X of these Bylaws.

Section 5. Term of Appointment

- A. Allied Health Professionals and Medical Staff Assistants will serve in a provisional status that may last up to, but not to exceed two years to allow sufficient time for evaluation. During this provisional period their professional competence, ethical and moral conduct shall be observed by the appropriate department chairperson or designee. At the end of the provisional period, the appropriate department chairperson will submit a written report to the Executive Committee indicating whether the Allied Health Professional is recommended for full appointment or whether the provisional period should be extended, indicating the recommended period of time.
- B. The Board will make all Allied Health Professional and Medical Staff Assistant appointments. The initial appointment will be made for a provisional period as defined in paragraph A above. Thereafter, the member will be subject to reappointment as set forth in Section 6.

- C. All Allied Health Professionals and Medical Staff Assistants shall be assigned to a department and supervised by that department unless state or federal regulations require assignment of those professionals to an individual physician.
- D. Notwithstanding the provisions of this Section 5, the privileges and membership of any Allied Health Professional and Medical Staff Assistant may be suspended or revoked at any time pursuant to Sections 8 and 9 of this Article, and the applicable provisions of the governing documents of MercyOne.

Section 6. Reappraisal and Reappointment

- A. Reappointments by the Board shall be for two years, based upon a recommendation of the Executive Committee.
- B. At least ninety (90) days prior to the expiration of reappointment, the Credentials Committee shall begin review of all pertinent information available on Allied Health Professionals and Medical Assistants whose term expires for the purpose of making a recommendation on the Allied Health Professional's and Medical Staff Assistant's reappointment and for the granting of practice privileges during the term of such reappointment.
- C. The Credentials Committee will initiate its review by requesting, in writing, at least the following information from the Allied Health Professional or Medical Staff Assistant;
 - 1. any change from the information provided by the Allied Health Professional or Medical Staff Assistant in the initial application;
 - 2. any change in the practice privileges requested by the Allied Health Professional or Medical Staff Assistant;
 - 3. the basis for any request for a change in practice privileges;
 - 4. the extent of the Allied Health Professional's or Medical Staff Assistant's continuing education efforts since last appointment or reappointment;
 - 5. Allied Health Professional's or Medical Staff Assistant's malpractice insurance coverage.
 - 6. information relating to the applicant's current physical and mental health, including information relative to communicable diseases.
- D. Simultaneously, the Credentials Committee will obtain, at a minimum, the following information from the appropriate department chairperson:
 - 1. whether the Allied Health Professional or Medical Staff Assistant has any physical or mental impairments that interfere with his/her ability;

2. the Allied Health Professional's or Medical Staff Assistant's attendance at required meetings;
 3. whether the member maintains timely, accurate and complete records;
 4. performance patterns as demonstrated by reviews and evaluations;
 5. a written evaluation by the sponsoring physician documenting the extent and quality of the work performed by the Allied Health Professional or Medical Staff Assistant during the preceding credentialing period as well as continued qualifications for the requested privileges;
 6. the Allied Health Professional's or Medical Staff Assistant's ability to work with members of the Medical Staff and with MercyOne personnel;
 7. quality assurance and risk management information; and
 8. documentation that the Allied Health Professional or Medical Staff Assistant has entered at least 50% of all orders electronically or, if not, evidence of completion of additional training in the use of the electronic medical record.
- E. In the case of advanced practice nurses, the application for reappointment will also be reviewed by the Vice President of Patient Care Services/Chief Nursing Officer, who will furnish a recommendation to the Credentials Committee.
- F. The Credentials Committee shall transmit its recommendation in writing to the Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff shall make written recommendations to the Board concerning the reappointment, nonreappointment, and/or revision of practice privileges of each Allied Health Professional and Medical Staff Assistant then scheduled for periodic appraisal. In each step above when nonreappointment or a change in the practice privileges is recommended, the reason for such recommendation shall be stated and documented.
- G. Changes in practice privileges at reappointment time are for a provisional period as with initial appointment and practice privilege delineation.

Section 7. Summary Suspension

- A. The Hospital President, at any time believing that it is in the best interest of patient care, may summarily suspend all or a portion of the practice privileges of an Allied Health Professional or Medical Staff Assistant on the recommendation or with a concurrence of:
1. the chairperson of a department of the medical staff or;
 2. the President of the staff; or

3. the Board.

The Hospital President shall notify the Allied Health Professional or Medical Staff Assistant, department chairperson, and Executive Committee of the Medical Staff of such summary suspension.

Section 8. Automatic Suspension

- A. Any Allied Health Professional or Medical Staff Assistant whose license or certificate is revoked or suspended shall automatically have all practice privileges at MercyOne revoked.

Section 9. Departmental Review

- A. Nothing contained in these Bylaws should be interpreted to entitle an Allied Health Professional or Medical Staff Assistant to review, hearing or appeal as identified in the Fair Hearing and Appellate Review Manual.
- B. When any Allied Health Professional or Medical Staff Assistant receives written notice from the department chairperson, Executive Committee of the Medical Staff, or Hospital President that will adversely affect that Allied Health Professional's or Medical Staff Assistant's initial appointment and delineation of practice privileges, the Allied Health Professional's or Medical Staff Assistant's status as an Allied Health Professional or Medical Staff Assistant or the Allied Health Professional's or Medical Staff Assistant's exercise of practice privileges, that individual shall be entitled to file a written grievance with the chairperson of the department to which the Allied Health Professional or Medical Staff Assistant has applied or been assigned and in which he/she has applied for or has exercised practice privileges. Such written grievance must be submitted within 15 days of receiving notice or the right is waived.
- C. Upon receipt of such a grievance, the department chairperson shall appoint a Committee to review the proposed action. The department Committee shall include, if available, an Allied Health Professional/Medical Staff Assistant or Allied Health Professionals/Medical Staff Assistants having the same or similar license or certification as the affected Allied Health Professional/Medical Staff Assistant.
- D. The Committee shall initiate an investigation and the Allied Health Professional or Medical Staff Assistant shall be afforded the opportunity for an interview before the Departmental Committee within 45 days of receipt of the grievance. At the interview, the Allied Health Professional/Medical Staff Assistant may provide information relevant to the circumstances giving rise as to the proposed action.
- E. A record of the findings of such interview shall be made and a report of the finding and recommendations of the Committee shall be made to the Executive Committee.

F. The decision of the Executive Committee shall be final.

Section 10. Allied Health Professionals' and Medical Staff Assistants' Release from Liability

Any person seeking appointment as an Allied Health Professional or Medical Staff Assistant, and each Allied Health Professional or Medical Staff Assistant, hereby agrees to release and give full immunity from civil liability and to execute any requested releases, in the same manner and to the same extent as is provided in Section 1 of Article XI.

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MERCYONE DUBUQUE MEDICAL CENTER

DUBUQUE, IOWA

POLICIES & PROCEDURES MANUAL

AND

RELATED DOCUMENTS

ARTICLE XV OF THE BYLAWS

REVISIONS APPROVED by MercyOne Dubuque Medical Center Medical Staff 2019, 2020, 2022, Feb-2023, May-2023, Nov-2023

REVISIONS APPROVED by MercyOne Dubuque Medical Center Board of Trustees 2019, 2020, 2022, Feb-2023, May-2023, Nov-2023

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POLICIES AND PROCEDURES MANUAL

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ARTICLE I: RULES AND REGULATIONS

Section 1. General: Pertaining To All Practitioners

- A. A patient may be admitted to the hospital only by a member of the Medical Staff with the specific exception of Psychiatric Nurse Practitioners, who are eligible for admitting and discharge privileges and Hospitalist Nurse Practitioners, who are eligible for admitting and discharge privileges on the Acute and Rehab/Skilled units. All practitioners shall be governed by the official admitting policy of the hospital.
- B. Provisional diagnosis must be available at time of admission.
- C. A patient to be admitted on an emergency basis who does not have a private practitioner may request any practitioner in the applicable department or service to attend to him/her. Where no such selection is made or if the physician is unavailable or declines, the member of the Active Staff on call will be assigned to the patient.
- D. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.
- E. A practitioner whose privileges have been suspended for non-compliance with Rules F. of this section or M. of Medical Records shall not admit patients under a colleague's or partner's name, nor may patients be admitted to the care of a practitioner whose privileges are suspended.
- F. A complete history and physical examination shall, in all cases, be legibly written or recorded within twenty-four (24) hours after admission of the patient. In the case of a surgical procedure the history and physical shall be completed prior to the procedure. If unable to complete, the reason shall be noted within the medical record and should include heart rate, respiratory rate, and blood pressure. A history and physical may be completed within thirty (30) days of an admission or surgical procedure; however, an appropriate assessment (which should include a physical examination of the patient to update any components of that patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed) must be recorded at the time of admission. The updated note must be included with the H&P prior to surgery or procedure. The history and physical examination shall include at a minimum:
- History of present illness
 - Past medical history including current medications and allergies
 - Pertinent physical exam based on chief complaint or reason for which the patient is being seen (cardiac and pulmonary exam required for pre-surgical evaluations)
 - Assessment and plan
 - Optional but encouraged:
 - social and family history
 - review of systems

- G. The licensed independent practitioner with privileges shall be responsible for the medical care and treatment of his/her patients in the hospital, for necessary special instructions, and for transmitting reports on the condition of the patient to the referring practitioner, to the patient and/or to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of the responsibility shall be entered on the order sheet of the medical record, or as an order within the electronic medical record.
- H. All orders shall be in writing or electronic form. An order shall be considered to be in writing if received verbally by a registered nurse, licensed physical therapist, licensed speech language pathologist, licensed occupational therapist, registered pharmacist, registered radiologic technologist, registered sonographer, registered MRI technologist, registered nuclear medicine technologist, certified medical laboratory technician, certified medical laboratory scientist, certified medical technologist, registered or certified respiratory therapist, registered dietician, certified alcohol and drug counselor, or radiology secretary (only noninvasive studies) employed or contracted by the hospital and signed either on paper or electronically by the attending practitioner. Such orders are limited to the specific area of professional expertise of the receiving individual. Verbal orders over the telephone shall be signed by those listed in the paragraph with name of the practitioner per their name. Within 15 days following discharge, the practitioner shall date, time, and authenticate with signature either on paper or electronically such orders (except for the Skilled Nursing Unit, the Rehabilitation Unit and Oakcrest Manor where orders will be signed either on paper or electronically on the practitioner's next visit). Medication orders can only be given to a registered nurse or a registered pharmacist.
- I. The medical staff delegates the responsibility of developing policies and procedures that minimize drug errors to the hospital's pharmacy services.
- J. The practitioner's orders must be written clearly, legibly and completely, or entered electronically. Orders which are illegible or improperly written will not be carried out until rewritten or understood by staff.
- K. The Pharmacy shall dispense generic drugs as approved by the Pharmacy and Therapeutics Committee unless the prescribing physician identifies a therapeutic reason that an individual patient should receive a specific trade name medication. In these cases, the physician is to note "Dispense as Written" on the physician's order sheet or in the comment section of the electronic order. Any concerns regarding the bioequivalency of a specific generic drug dispensed by the pharmacy will be referred to the Pharmacy and Therapeutics Committee for review and action.
- L. The licensed independent practitioner will limit the duration of drug therapy in the absence of the prescriber's specific indication of duration of drug therapy through the use of criteria defined by the Pharmacy and Therapeutics Committee. The prescriber may override the automatic stop date by specifying a particular duration for therapy. Automatic stop dates for the following drug categories are assigned as follows:
- Controlled substances and anti-infective agents – 30 days

All medication orders are discontinued when the patient is transferred to Skilled Nursing status.

- M. Restraints (leather/soft) may be used on any nursing unit as outlined in the restraint policy in the patient care services policy manual. All orders for restraints/seclusion must include the type of restraint (leather/soft), time limit, and the reason for the specific episode. Orders must be signed, dated and timed by the practitioner writing or entering the order. PRN orders are not acceptable. Orders are time limited to 24 hours for adults and children for medical reasons. For patients with primary behavioral health needs orders are time limited to: 4 hours for adults, 2 hours for children and adolescents ages 9-17, 1 hour for children under age 9.
- N. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she will provide either electronic or written authorization to permit another attending practitioner to attend or examine his/her patient except in an emergency. The consultant shall respond in a timely manner consistent with the patient's condition but in no case later than twenty-four (24) hours. The consultant will document the findings and recommendations in the medical record within twenty-four (24) hours.
- O. Each licensed independent practitioner, not a resident in the city or immediate vicinity, shall name a licensed independent practitioner who is a resident of the city, who may be called to attend his/her patients in an emergency. In the event that neither is available, the President of the Medical Staff or Hospital President will have the authority to call any member of the licensed independent practitioner to attend the patient.
- P. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- Q. At the time of discharge, the practitioner will complete the record, state final diagnosis and sign the record either on paper or electronically.
- R. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient shall be requested to sign the Refusal of Care form.
- S. When a donor organ is obtained from a brain-dead patient, the medical record of the donor shall include the date and time of brain death, documentation by and identification of the two physicians who determined the death and the method of transfer and machine maintenance of the patient for organ donation, as well as an operative report.
- T. The Medical Staff shall cooperate with the hospital administration in the education of health care professionals by giving such personal supervision and educational programs as are necessary.
- U. Upon receiving staff privileges, the practitioner shall sign a statement acknowledging that

the practitioner has read and understands the entire attestation paragraph, including the penalty notice, as required by Federal Regulations.

- V. It will be the practitioner's responsibility to obtain an informed consent which documents that benefits, risks and alternatives have been discussed with the patient or appropriate representative in the case of minors, or in the case of inability of the patient to comply, for all noninvasive and invasive procedures, and all other procedures as outlined in the Patient Care Manual under Informed Consent/Guardianship in the Patient Rights section. Additional specific consent is required for both regional and general anesthesia as well as those instances when sedation is utilized. Consent is also required for blood or blood product transfusions. With the exception of life-threatening emergencies any and all required consents must be obtained prior to the procedure and documented on the appropriate form within the paper portion of the chart.
- W. Do not resuscitate orders must be clearly documented and progress notes must indicate discussion was held with patient and/or family regarding Do Not Resuscitate orders. When Advanced Directives and/or Living Wills are present, the electronic or written documentation must include reference to these documents if decisions as to life support mechanisms or extraordinary medical care are necessary.
- X. Whenever any minor patient is examined or treated and where there is suspicion of child abuse, the attending practitioner shall immediately complete a written report and notify the Department of Human Services.
- Y. Whenever any dependent adult is examined or treated and where there is a suspicion of dependent adult abuse, the attending practitioner shall immediately complete a written report and notify the Department of Human Services.

Section 2. Specific: Pertaining to Departments and/or Services

A. Obstetrical

1. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy or facsimile of the practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
2. A discharge summary is not required for vaginal deliveries, at a minimum a final summation progress note shall be sufficient but shall contain the final and discharge diagnosis summary of hospital course, condition on discharge and discharge plan and/or follow-up instructions.
3. C-Sections require a discharge summary to be recorded by the discharging physician.

4. The attending physician shall be responsible for completing a birth certificate within three (3) days after delivery.
5. Any live-born fetus with subsequent demise requires a birth and death certificate and cannot be disposed of by the hospital.
6. A stillborn fetus less than twenty (20) weeks gestation as determined by the practitioner may be disposed of by the hospital with the parents' permission.
7. A stillborn fetus greater than or equal to twenty (20) weeks gestation requires the services of a funeral director.
8. Patients who present to OB triage will receive an initial triage assessment and medical screening. In the absence of the immediate attendance of a physician, this assessment and screening may be performed by a registered nurse who meets the following criteria:
 - a. Current licensure with the state of Iowa or a compact state.
 - b. Successful completion of an individualized orientation program.
 - c. At least one year of experience in labor and delivery managing labor and assessing triage patients. Registered nurses with less than one year of such experience will assess and triage the obstetrical outpatient under the supervision of a preceptor/primary OB nurse.
 - d. Successful completion of the AWHONN fetal monitoring class.

B. Psychiatric Services

1. Restraints/Seclusion

- a. The use of restraints and seclusion room treatment will be utilized within MercyOne. Use of the seclusion room will be limited to the Psychiatric Services inpatient unit. Restraints (leather/soft) may be used on any nursing unit following the policy/procedure outlined in the Interdisciplinary Patient Care Manual.

An order must be obtained within 1 hour after initiation of restraint or seclusion. The patient must be seen in person (face-to-face assessment) within 1 hour after initiation of restraint/seclusion by a physician or other licensed independent practitioner (LIP); or a trained RN. All orders for restraints/seclusion must include the specific type of restraint (leather/soft), age specific time limit, and the behavior management reason for the specific episode. All orders must be written by a Licensed Independent Practitioner (LIP) and be time limited, dated, and signed. If the restraint order is written

or entered by a physician other than the attending, the attending physician must be consulted as soon as possible. PRN orders are not acceptable. Orders are time limited to 24 hours for adults and children for medical reasons. For patients with primary behavioral health needs, orders are time limited to: 4 hours for adults; 2 hours for children and adolescents ages 9-17; 1 hour for children under age 9. A face-to-face assessment by an LIP must be done every 24 hours when restrained or secluded, with a progress note/order that states the behavior management reason for the restraint or seclusion.

2. E.C.T.

- a. Before initiating electroconvulsive therapy to a child or adolescent psychiatric patient, two qualified psychiatrists, at least one of whom has had specific training or experience in the treatment of children and adolescents, and who are not directly involved in the treatment of the patient shall examine the patient, consult with the psychiatrist responsible for the patient and document in the patient's medical record their concurrence with the decision to administer such therapy.
- b. When E.C.T. is administered to an adult psychiatric patient, an informed consent for a series of treatments must be obtained from the patient or his or her legal representative by the practitioner.
- c. E.C.T. will be administered in accordance with a protocol approved by the Departments of Psychiatry and Anesthesia.
- d. Anesthesia for all E.C.T. will be administered by an anesthesiologist or qualified CRNA.
- e. No inhalation anesthetics will be administered in the E.C.T. treatment room.
- f. Laboratory tests required are the same as prior to surgery.
- g. Chest x-ray and EKG requirements are the same as prior to surgery.
- h. Same Day E.C.T. will be treated utilizing the same guidelines as inpatients with the exception of:
 - i. Initial history and physical may be maintained on record if on each occasion of E.C.T. an update is written on the progress notes by the psychiatrist indicating the patient's medical status.
 - ii. When a patient receives E.C.T. on an outpatient basis, the patient will have a physical exam completed within thirty (30) days prior to the E.C.T. and updated immediately prior to the procedure.

- i. Adverse conditioning techniques require specific justification documented in the medical record. They must be implemented according to the behavioral management policy.
- j. Any patient admitted to the inpatient psychiatric or substance abuse services from the Emergency Room must have a medical evaluation prior to admission.

C. Surgery

- 1. At the time of transfer to surgery, it is recommended that the "sending unit" nurse place all active medication orders into suspend status.
- 2. Scheduling of Cases
 - a. Cases are scheduled in the operating room by the O.R. staff and controlled by the Perioperative director.
 - b. Scheduling at MercyOne is on a "first come, first served" basis, with the exception of designated block times.
 - c. Elective surgery is scheduled five (5) days a week until 5 p.m. The weekend and evening hours (after 5 p.m.) is open to emergent/urgent cases on a "to follow" basis.
 - d. The following information is necessary to make a reservation for a surgical procedure:
 - i. date
 - ii. time
 - iii. patient's name and birthdate
 - iv. procedure
 - v. type of anesthesia
 - vi. group to administer anesthesia
 - vii. units of blood required
 - viii. surgeon
 - ix. special requests for equipment/supplies

- x. patient's telephone number
 - xi. patient type – inpatient or same day surgery
 - xii. person scheduling – initials and date.
3. Change of Schedule in Case of Emergency Surgery
- a. In the event of an emergency, the Perioperative director in consultation with the anesthesiologist has the authority to rearrange the schedule to allow time for the case. It is the director's responsibility to notify the appropriate surgeon and anesthesiologist. Any exceptional problems will be referred to the chairperson of the Department of Surgery.
 - b. In the event of a life-threatening emergency, the Perioperative director has the authority to assign any available anesthesiologist or nurse anesthetist to the case.
4. Requirements Prior to Anesthesia and Operation
- a. All anesthesia will be administered either by an anesthesiologist or qualified CRNA.
 - b. Moderate sedation must be administered by Medical Staff members with proper credentials according to guidelines outlined in the Moderate/Deep Sedation/Analgesia Policy which is included in the Patient Care Manual. A copy of that policy is included in the Policies & Procedures Section of these Bylaws documents.
5. Minor Surgery Patients
- a. Patients being admitted for minor surgery on the day of the scheduled surgery shall be admitted in a time frame determined by ambulatory services prior to the surgery to allow time for the necessary work-up.
6. Preoperative Evaluation and Documentation
- a. The surgeon shall be held responsible for the preparation of the complete medical record prior to the surgery. This includes identification data, complaint, personal history*, family history*, history of present illness*, physical examination*, special reports such as consultation, clinical laboratory, x-ray as well as provisional diagnosis and assessment of risks and benefits and need to administer blood or blood components. When the above information is not recorded before the time stated for the operation, the anesthesiologist or nurse anesthetist must ask the surgeon to document

on the chart any medical problems. If the above is not accomplished, the operation may be cancelled by an anesthesiologist unless the attending surgeon states in writing that the delay would be detrimental to the patient.

* Not required for outpatients who receive only local anesthesia or I.V. Blocks, unless medical problems would require the history and/or physical.

- b. The medical record shall include a pre-op assessment which shall be done either by the anesthesiologist or nurse anesthetist.
 - c. Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a “time out,” to confirm the correct patient, procedure and site, using active – not passive – communication techniques.
 - d. Medical Staff member will mark the surgical site in cases involving right/left distinction of multiple structures or levels.
7. Laboratory procedures to be completed prior to surgery involving general or regional anesthesia are outlined in the Patient Care Manual. A copy of that policy is included in the Policies & Procedures Section of these Bylaws documents. These procedures will be done within the time frame specified in the pre-op diagnostic testing policy (IDPC.420).

8. Informed Consent and Forms

Informed Consent is consent given by a patient (or by the legally authorized representative) for care, treatment and services after receiving information either verbally or in writing from the practitioner. The patient or the legally authorized representative shall have opportunities to ask and have questions answered in a satisfactory manner. The practitioner’s duty to disclose to patient is measured by the patient’s need to have access to all information material to making a truly informed and intelligent decision concerning proposed medical procedure or procedures. Absent extenuating circumstances, a patient has the right to exercise control over his or her body by making an informed decision concerning whether to submit to a particular medical procedure. Practitioners are responsible for disclosing information they know would be significant to a reasonable person in the patient’s condition and circumstances. Practitioners have no obligation to provide treatment or services deemed medically unnecessary or inappropriate. In order to give informed consent, the patient must be informed of:

- a. His/her health status, diagnosis, and prognosis;
- b. The nature and purpose(s) of the proposed care, treatment, services, medications, interventions, or procedures;

- c. Associated benefits, risks, or side effects, including potential problems related to recuperation. Specifically, disclosure of risks must include any known risk of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with the procedure or procedures;
- d. The probability of each such risk if reasonably determinable;
- e. The likelihood of achieving care, treatment, and service goals;
- f. Reasonable alternatives to the proposed care, treatment, and service and the associated risks, benefits, and side effects;
- g. The right to refuse treatment and any consequences associated with the refusal; and
- h. When indicated, any limitations on the confidentiality of information learned from or about the patient, such as when confidential information may have to be disclosed.
 - i. Surgical. It will be the responsibility of the attending practitioner to inform the patient about the expected benefits of the proposed surgical procedure as well as alternatives and the risks associated with having or not having the procedure. After the patient has received this information, it will be the responsibility of the attending practitioner or the registered nurse to secure the signature of the patient on the Consent for Surgical Treatment form. In the event that the patient is a minor unable to consent because of medical condition, consent will be obtained from the legal representative.
 - ii. It will be the responsibility of the anesthesiologist or the nurse anesthetist to inform the patient about the expected benefits of the proposed anesthetic method as well as the alternatives and the risks of anesthesia. After the patient has received this information, it will be the responsibility of the anesthesiologist, the nurse anesthetist, or the registered nurse to secure the signature of the patient on the Consent for Anesthesia form. In the event that the patient is a minor or unable to consent because of medical condition, consent will be obtained from the legal representative.
 - iii. No operation shall be performed, nor general or spinal anesthetic administered without the informed written consent of the patient or his/her legal representative per the Informed Consent policy.
 - iv. Consent is implied in a true emergency in which immediate care,

treatment, and services are required for preservation of life or limb. In such circumstances, informing and securing the express consent of a legal guardian or representative (if any) is encouraged but not required.

There are three (3) important requirements for the emergency to justify acting without consent:

- There must be a threat to life or health (serious permanent harm) of the patient;
- The threat must be an immediate one and under the circumstances there is insufficient time to obtain consent; and
- The responsible practitioner and the hospital staff shall document in the medical record the medical need for proceeding with care, treatment, and services without consent.

The medical record documentation shall:

- Clearly indicate the immediacy of the threat to life or health (the nature and magnitude);
- Include the attempts made to secure a consent and why a valid consent could not be obtained from the patient or patient representative; and
- Indicate the performed procedure was only that which was necessary to remove the immediate threat to the patient's life or health.

If there is sufficient time, a consultation should be obtained with corroborative statements by the consultant indicating that the procedure is indicated in view of the imminent, life-threatening situation. Consultation should show evidence of a review of the patient's record by the consultant's opinion and recommendation. This report should be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, should be recorded prior to the operation.

9. Outpatient procedures requiring general anesthesia shall only be done in the Operating Room, E.C.T. Department, Radiology, C-section and Delivery Rooms according to the same standards as inpatient procedures.
10. Care and Transport of Patients
 - a. Patients shall be transferred from surgical suite to the recovery room by the anesthesiologist or nurse anesthetist who administered the anesthesia and O.R. staff members.
 - b. Anesthesiologists or nurse anesthetists who administered the anesthesia on

a particular patient shall remain in Post Anesthesia Recovery until he/she is sure the patient is in satisfactory condition.

- c. Patients transferred from PACU or OR to the nursing unit are accompanied by a registered nurse with the exception that those patients that have a cumulative score of 8-10 on Modified Aldrete Scoring System or all categories the same as baseline may be transported by a nursing assistant.

11. Post Anesthesia Recovery

- a. Post Anesthesia Recovery shall be under the medical direction of an anesthesiologist.
- b. All patients who have undergone the following anesthetics shall be admitted to Post Anesthesia Recovery.
 - i. General
 - ii. Spinal
 - iii. any patient deemed necessary to receive care in the post anesthesia unit determined by anesthesia provider.
 - iv. patients receiving conscious sedation in the operating room that do not meet discharge criteria.
- c. The anesthesiologists or nurse anesthetists shall determine when a patient is ready to be transferred from Post Anesthesia Recovery.

12. Efficient Utilization of Operating Rooms

- a. The assignment of cases to the specific operating room shall be made by the Operating Room Director.
- b. In emergency cases which are not life-threatening, one (1) hour notification to the operating room and anesthesia is desirable.
- c. Universal Precautions will be followed for all cases.

13. Consultation

Except in emergency, consultation with another member of the Active Medical Staff is suggested in all major cases in which the patient is considered a high risk. The consultant shall always complete and sign a record of findings and recommendations.

14. Operative Reports

- a. IMMEDIATE POSTOP NOTE: An immediate postoperative note shall be entered into the medical record prior to the patient going to the next level of care and shall contain name of surgeon, name of assistant (if any), procedure performed, description of findings, estimated blood loss (must state none), specimens (if any) and postoperative diagnosis. The completed immediate postop note shall be authenticated, dated and timed by the surgeon and shall be entered in the medical record immediately after surgery to provide pertinent information for use by any practitioner who is required to attend the patient. The patient will not be transferred to the next level of care until the immediate postop note is completed.
- b. OPERATIVE REPORT: Operative reports shall be entered in the medical record after surgery and shall contain name of surgeon, name of assistant (if any), type of anesthesia, complications, description of techniques, description of findings, specimens removed (if any), estimated blood loss, implants or grafts (if any) and postoperative diagnosis. The completed operative report shall be authenticated, dated and timed by the surgeon and filed in the medical record as soon as possible after surgery.
- c. Patients will be held in PACU (Post Anesthesia Recovery) until an Immediate Post-Op note or Operative Report is completed. The patient will not be transferred to next level of care or discharged until either is completed and in the electronic medical record.

15. Tissue Examination

- a. All tissue removed during surgery shall be sent to the hospital's Pathology department for pathologic evaluation. This includes tissues that may be forwarded to another institution for special studies. Specific exemptions to this mandatory submission are listed below (f).
- b. All tissue remains the property of the hospital.
- c. The removal of all tissues, whether or not submitted to pathology should be documented in the operative report.
- d. Physicians should consider submitting exempted tissues if there is clinical concern of unknown disease, infection, neoplasm, potential medical-legal implications, or for industrial quality assurance.
- e. At the discretion of the pathologist responsible for the specimen, certain specimen types may be examined by gross examination only. These include (but not limited to) all specimens that are submitted from the list below (f). Such circumstances will be superseded by a

physician/surgeon's explicit request for a microscopic examination. All other specimens will include both gross (macroscopic) and microscopic examination.

- f. The following may be exempted from mandatory requirement for submission to the Pathology laboratory. If these specimens are submitted, it is at the discretion of the pathologist to perform gross examination only unless a microscopic exam is specifically requested.
- i. Specimens (e.g. bullets) that for legal reasons are given directly to law enforcement
 - ii. Orthopedic appliances and other medical devices (e.g. IUD's, electronic devices like pacemakers, etc) without any attached soft tissue.
 - iii. Therapeutic radioactive sources
 - iv. Teeth without adherent tissue.
 - v. Calculi
 - vi. Foreskin from newborn infant circumcision
 - vii. Middle ear ossicles in the absence of suspicion for neoplasm
Dental follicles removed during routine extractions.
 - viii. Fingernails and toenails (in the absence of a pigmented nail be lesion)
 - ix. Intervertebral disc tissue
 - x. Plastic surgery tissue removed for cosmetic purposes) nasal cartilage, blepharoplasties, abdominal skin and fat, lipectomies of other types, scars other than from sites of previous malignant neoplasms, excess labial tissue at labioplasty).
 - xi. Tonsils in patient less than 16 years of age, without asymmetry or other clinical suspicion for disease.
 - xii. Hernia Sacs in patients without a concern or history of malignancy.
 - xiii. Varicose veins and unused saphenous veins harvested at the time of bypass.

- xiv. Bone, cartilage, and soft tissue fragments removed in the course of orthopedic or podiatric procedures to correct congenital, traumatic, or routine degenerative conditions without clinical or intraoperative suspicion of significant coexisting disease. Specific examples of such specimens include routine total joint replacement, arthroscopic shavings, loose bodies, sesamoid bones, hallux, valgus/pes excavatum corrections, synostoses, bone spurs traumatically injured fragments of soft tissue, and degenerated bone ends and associated soft tissue for routine arthroplasty procedures.
- xv. Routine atheromatous plaques, aneurysms contents, and blood clots,
- xvi. Bone (e.g. rib) or other tissue incidentally removed to provide surgical access.
- xvii. Cataracts
- xviii. Vaginal and labial mucosa incidentally removed during hysterectomy or anterior/posterior repair.
- xix. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics without any known fetal complications

16. Rules governing advisability for having surgical assistants at a surgical procedure area as follows:

- a. In any procedure with unusual hazard to life, there must be a qualified physician present and scrubbed as first assistant.
- b. A qualified assistant is defined as a physician designated by the Board as being qualified to assist.

17. Conductivity and Environmental Control

The Director of Plant Engineering shall see that the necessary safety inspections and checks in regard to environmental control are accomplished. It is the Director's responsibility to see that the necessary records are kept of these checks and filed. One copy shall be furnished to the Director of the Operating Room.

18. Radiation Safety

- a. Surgical Rooms – Conventional portable x-ray machines:
When a surgical procedure requires x-ray services, all surgical personnel

should leave the room during the x-ray exposure or stand behind a lead door. The surgeon, anesthesiologist, and x-ray technologist remaining in the room during the x-ray exposure will wear lead protective aprons.

- b. Surgical Rooms - Fluoroscopy:
All personnel will wear lead protective aprons and radiation badge monitors during a surgical procedure requiring fluoroscopy. Real time continuous fluoroscopy is discouraged. Intermittent fluoroscopy with disc recording should be used as much as possible.

Section 3. Medical Records

- A. All records and films shall be the property of MercyOne. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court subpoena or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner.
- B. The attending practitioner shall be held responsible for the preparation of a complete medical record for the hospital file. This includes: identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, x-ray, and others; provisional diagnosis; medical or surgical treatment, operative report, condition on discharge; progress notes; autopsy or tissue report when available, and final diagnosis. In addition, instructions for follow-up given to the patients should be delineated in either the final progress notes or discharge summary.
- C. All orders and reports completed by Allied Health Professionals with the exception of licensed independent professionals (i.e. nurse practitioner and nurse anesthetists) who are supervised by a member of the Medical Staff shall be authenticated by him/her. For example, when specified professional personnel have been approved for such duties as taking medical histories and some aspects of a physical examination, such information shall be authenticated by the responsible medical staff member.
- D. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written or electronically entered at least daily on all patients.
- E. Consultation shall show evidence of a review of the patient's record by the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, shall be recorded prior to the operation.

- F. Copies of reports of clinical lab, x-ray, and other tests performed in the practitioner's office shall be incorporated into the medical record pertinent to that patient's hospitalization.
- G. All clinical entries in the patient's medical record shall be accurately timed, dated and authenticated.
- H. Standardized abbreviations, acronyms and symbols are approved and used by Medical Staff. A "Do Not Use" list of symbols and abbreviations has been developed. Members of the Medical Staff will refrain from using items on the "Do Not Use" list.
- I. Final diagnosis shall be recorded in full, without use of symbols or abbreviations, and dated and signed either on paper or electronically by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.
- J. A discharge clinical resume (summary) shall be entered on all medical records of patients who expire regardless of length of stay and patient type (excluding hospice, respite, and ED deaths, as the note will suffice), hospitalized over 48 hours except for vaginal deliveries. For vaginal deliveries, a final summation progress note shall be sufficient but shall contain the final and discharge diagnosis, summary of the hospital course, condition on discharge and discharge plan and/or follow-up instructions. In all instances, the content of the medical record must be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated, dated, and timed by the discharging physician. The discharge summary shall include at a minimum:
- Final or discharge diagnosis
 - Surgical procedures (if any were performed)
 - Summary of hospital course
 - Condition on discharge
 - Discharge plan and/or follow-up instructions
- All summaries shall be authenticated, dated and timed by the discharging physician within 72 hours of discharge.
- K. Access to all medical records of all patients shall be afforded to members of the Medical Staff and other authorized parties for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Hospital President, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in MercyOne.
- L. A medical record will not be considered complete until all required components have been entered and authenticated by all responsible providers.
- M. The patient's medical record shall be completed at the time of discharge. Medical Records

will be considered delinquent when they are 15 days past-due following discharge. On Tuesday of each week a letter is sent to each medical staff member who has four or more records ten days overdue or when any records are 30 days overdue. That letter contains the number of charts over ten days old or older and the number of suspensions the medical staff member has received within this twelve-month period. On Thursday, a reminder telephone call is made to the office if those records remain incomplete.

On Monday at 12:00 noon, if those records (now at least 15 days overdue) are still incomplete, the medical staff member's admitting and elective scheduling privileges are suspended until the records are completed. If the medical staff member is on vacation during the time 10 day records are identified and he/she has notified the HIM Department before leaving, he/she is not placed on the delinquent list. If the medical staff is on the list before a vacation, he/she is kept on the list until the records are completed. Physician or designee will notify the HIM Department when his/her medical records have been completed. HIM staff will confirm that all records have been completed and will notify the President and appropriate departments that admitting and scheduling privileges have been restored.

The medical staff member with five temporary suspensions in any rolling twelve-month period will be required to meet personally with the Medical Staff Executive Committee to explain his/her position and agree to comply with the policy. Suspensions following the meeting with the Medical Staff Executive Committee will automatically trigger the following:

1. The sixth suspension within a twelve-month period will result in a one-week suspension of all admitting and scheduling privileges.
2. The seventh suspension within a twelve-month period will result in a two-week suspension of all admitting and scheduling privileges.
3. The eighth suspension within a twelve-month period will result in a four-week suspension of all admitting and scheduling privileges.
4. Any further suspension will automatically trigger permanent suspension requiring reapplication to the medical staff.

Letters of incomplete medical records sent to medical staff members with five or more suspensions will be sent by the Medical Staff President with a copy to the Mercy President via certified mail with return receipt requested, which will require the medical staff member's signature.

- N. When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty (60) days.

Section 4. Hospital Deaths

- A. In the event of a hospital death, the deceased shall be pronounced dead by the practitioner or his designee within a reasonable time. In the event of a patient whose death is anticipated, a licensed physician assistant or registered nurse may make the pronouncement of death within a reasonable time. The body shall not be released until an entry has been made and signed, either on paper or electronically, in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible terminal disease wherein the patient's course has been adequately documented.
- B. Every licensed independent practitioner shall be appropriately interested in securing autopsies that shall be performed by the hospital pathologist, or by a physician to whom delegated. The autopsy case will be discussed with the patient's attending Medical Staff or other designated physician (if available) prior to the autopsy being performed.
- C. Per Policy NSPP.254 – Chapter 45, autopsy should be considered in the following cases of death:
1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
 2. Deaths in which the cause is not known with certainty on clinical grounds.
 3. Cases in which an autopsy may help allay concerns of the family regarding the death and provide reassurance to them regarding same.
 4. Deaths in which autopsy may help explain extent of disease and/or response to therapy.
 5. Unexpected or unexplained deaths following any dental, medical or surgical diagnostic procedures and/or therapies and not subject to a forensic medical jurisdiction.
 6. Deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards.
 7. Sudden, unexpected and unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.
 8. Deaths in which the patient sustained or apparently sustained an injury while hospitalized and not subject to a forensic medical jurisdiction.
- D. When death occurs suddenly, directly or indirectly due to an accident or under suspicious circumstances, a report must be made within twenty-four (24) hours by the supervisor in charge at the time of death to the Medical Examiner whose permission must be secured

before the body may be removed from the hospital. This regulation also applies to surgical deaths that occur in the operating and recovery rooms.

- E. When death appears imminent in a patient on life support measures, such condition must be documented on the chart by two (2) practitioners, one (1) of whom is attending the patient. A practitioner physically taking care of the patient must be in attendance when the life support measures are disconnected on such a patient.
- F. A discharge or death summary is required on all patients who expire regardless of length of stay and patient type. Excluding hospice, respite, and ED deaths, as the note will suffice.

Section 5. Infection Control

A. Infection Surveillance:

Infection surveillance will be the responsibility of the infection preventionist under the direction of the Infection Control Officer. The infection preventionist will perform the following duties:

1. supervise the surveillance program;
2. attempt to determine the source of infection;
3. bring to the attention of the Infection Control Committee problems detected through the surveillance system; and
4. report specified communicable diseases to the local public health department.

B. A Sanitary Environment:

Hospital departments concerned with a sanitary environment (e.g., nutrition, environmental services, plant engineering, etc.) are to establish and carry out infection control policies pertinent to the operation of their departments. These are to be periodically reviewed and updated by the Infection Control Committee.

Environmental culturing is the responsibility of the infection preventionist or designated laboratory personnel. Limited environmental culturing may be carried out through the Infection Control Committee for the following objectives:

- a. investigation of hospital acquired infections;
- b. education of hospital personnel; and
- c. monitoring of microbial flora in areas, objects and equipment specified by the Infection Control Committee.

C. Procedures for the Isolation of Infected Patients:

The procedure for the isolation of infected patients will be determined by the Infection Control Committee and will be periodically reviewed and revised to conform to current standards of practice. Problems with isolation techniques are brought to the attention of the Infection and Environmental Control Committee by the infection preventionist or designee.

D. Programs for the Education of Personnel in the Control of Healthcare Associated Infection (HAI):

The infection preventionist will be responsible for coordinating the orientation of all new employees and for the inservice, continuing education of all departments relative to prevention and control of infection. The infection preventionist will periodically report these activities to the committee for their evaluation and recommendations.

E. Departmental Policies and Procedures Designed to Prevent Infection:

There shall be specific written infection control policies and procedures for all services in the hospital. These policies will be subject to the approval of the Infection Control Committee and will be periodically reviewed for reapproval or revision.

F. Authority of the Infection Control Committee:

1. Recommendations of the committee affecting hospital departments shall be forwarded to the appropriate department for approval. In those instances where the recommendations are not approved by the department involved, they will be referred to hospital administration.
2. Recommendations of the committee affecting clinical departments shall be forwarded to the appropriate department(s) for approval. Recommendations affecting all clinical departments shall be brought before all departments for approval. In those instances where the recommendations are not approved, they will be referred to the Medical Staff Executive Committee for arbitration.

G. Authority of the Infection Control Officer:

In the interest of uniform application of isolation regulations and protection of all patients and personnel, the Infection Control Officer and/or infection preventionist will have the authority to order appropriate cultures and/or isolation of a patient and personnel. A consultation will be obtained with the attending physician when such action is deemed necessary. In situations where there occurs an epidemic, threatened epidemic, or unusual cluster of infectious disease, the Infection Control Officer will have the authority to order appropriate control measures including isolation, investigational procedures and closure of a unit. The Infection Control Officer shall also have the authority to prohibit those persons suspected to be carriers or in the communicable phase of an infectious disease process from

working in areas of direct patient contact until appropriate measures have been taken to reduce the possibility of cross infection. In the event that an Infection Control Officer is not available, another physician from the hospital's Infection Control Committee shall be contacted and will have full authority for making necessary decisions.

Section 6. Healthcare Professionals' Responsibility in Patient Care

1. If a healthcare professional has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the health professional shall call the situation to the attention of the nurse in charge of the floor at that time, and also provide the nurse a written statement regarding the situation. The nurse in charge will then contact the attending practitioner and invite comment. If the problem is not solved by this means the nurse in charge shall refer the matter to the Vice President of Patient Care Services. The Vice President of Patient Care Services shall, if warranted, bring the matter to the attention of the Chairperson of the Department wherein the practitioner has clinical privileges. Where circumstances are such that it presents an immediate problem for the patient, the Chairperson of the Department or President of the Medical Staff shall request a consultation, consisting of an immediate review of the medical record with the attending practitioner.
2. If any other healthcare professional has any reason to doubt or question the care provided, or the interpretation of an order, that healthcare professional will contact the attending practitioner, and also verbally inform the nurse in charge of the floor at that time of this action. If the matter is not resolved between the attending practitioner and the healthcare professional, the healthcare professional will provide the nurse in charge a written statement regarding the situation, who will in turn, refer the matter to the Vice President of Patient Care Services, and the steps outlined from this point in the above paragraph will be followed.

Section 7. Long Term Care

A. MercyOne Dyersville Senior Care

1. There must be a written order for admission. The order is written on the Physician Order Form and signed by the attending practitioner. All patients admitted to the MercyOne Dyersville Senior Care shall have orders which include transfer information, medication, treatment, diet, activity, specific diagnosis, rehabilitative services required, rehabilitative potential (programs) of the patient, and plans for continuing care.
2. All orders shall be in writing or electronic form. An order shall be considered to be in writing if received verbally by a registered nurse, licensed practical nurse, licensed physical therapist, licensed speech language pathologist, licensed occupational therapist, registered pharmacist, registered radiologic technologist, registered sonographer, registered MRI technologist, registered nuclear medicine

technologist, certified medical laboratory technician, certified medical laboratory scientist, certified medical technologist, registered or certified respiratory therapist, registered dietician certified alcohol and drug counselor, or radiology secretary (only noninvasive studies) employed or contracted by the hospital and signed by the attending practitioner. Verbal orders over the telephone shall be signed by the practitioner on the practitioner's next visit. Medication orders can only be given to a registered nurse or a licensed practical nurse.

3. The physician's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
4. A member of the active staff shall be responsible for the medical care and treatment of each patient in the nursing home. In planning the medical care of this patient, prior to or upon admission, the physician should make a medical evaluation of the patient's immediate and long-term care needs. The attending physician shall perform a physical examination of the patient and provide the facility with an admitting diagnosis, statement about the patient's functional status, diet orders, medications, treatments, rehabilitation potential undertaken by the patient and plans for continuing care and when appropriate, planning for discharge.
5. Each member of the medical staff who does not reside in the immediate vicinity shall designate an alternate physician or shall advise his physician exchange as to whom may be called to see his patients for regular or emergency care when the attending physician is not available. In the event that neither the attending physician nor the designated alternate physician is available to examine and treat a patient requiring immediate attention, the Medical Director of MercyOne Dyersville Senior Care shall have the authority to call another physician to treat the patient.
6. The admitting practitioner shall be held responsible for giving such information necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.
7. For the protection of the nursing home patients and the medical and nursing staff, potentially suicidal patients shall be referred to another facility.
8. Each attending physician shall be aware of the availability of social, psychological, and other non-medical aspects of care for his patient so that he may assure himself that such care is compatible with the medical condition of the patient.
9. The attending physician shall consult with the Medical Director of MercyOne Dyersville Senior Care and/or Director of Patient Care when, in the judgment of either, there is a question as to the appropriate placement or the advisability of transfer of any patient originally admitted by the attending physician.

10. Where possible, the attending physician shall reserve the right to seek consultation. As part of the treatment plan, this should be discussed with the patient. The facility's administrative personnel, Medical Director of MercyOne Dyersville Senior Care, and other involved personnel can independently request a consultation without prior approval of the attending physician. The attending physician will be informed of the treatment changes.
11. Routine labs may be performed on admission with consideration as to what has been completed in the last 30 days and with a physician order. A two-step TB test will be performed on admission on all patients except those who have tested positive previously, and on which there is appropriate documentation of treatment received at that time.
13. Prescriber order sheets are signed on admission to the facility and every 2 months thereafter. If signed orders are not received, prescribing provider will be contacted. All medication orders are discontinued when the patient is transferred to a different level of care or discharged.
14. No medication will be discontinued until the attending physician is notified, preferably between 7:00 a.m. and 3:00 p.m. on the day the order expires.
15. Annual re-examination of the patient is required to be done by the attending physician and findings recorded in the medical record.
16. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. If a resident believes a physician visit is not necessary, or does not want a physician to visit, a resident has the right to refuse the visit. Explanation must be given to the resident of the results of such a refusal and alternatives that may be available. If a seriously ill resident continues to refuse treatment such that the refusal effects a significant change in the resident's condition, the facility should reassess the resident and institute care planning changes in the context of the resident's directions regarding treatment.
17. Patients shall be discharged only on written order of the attending physician. Should a patient leave the nursing home against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
18. Those patients who die in the nursing home shall be pronounced dead by the attending physician or, in his absence, another licensed physician, licensed physician assistant, or registered nurse within a reasonable time. The body shall not be released until an entry has been made and signed, either on paper or electronically, in the medical record of the deceased by the attending physician or the physician's designee.

19. Patients with an infection needing isolation technique shall be treated with appropriate precautions within the nursing home.
20. A patient discharged from the nursing home shall have his medical record closed.
21. When death occurs suddenly, directly or indirectly, due to an accident or under suspicious circumstances, a report must be made by the Administrator on call, Vice President of Patient Care Services and/or Director of MercyOne Dyersville Senior Care, to the Medical Examiner and their permission must be secured before the body may be removed from the nursing home.
22. Each attending physician shall participate in a quality assurance program. Such participation may extend to medical care evaluation of patient care.
23. For utilization review purposes, the attending practitioner is required to document the need for continued intermediate long term care placement after a specific period of stay as designated by the Long Term Care, PSRO and document plans for post nursing home care where applicable.
24. The attending physician shall be held responsible for the preparation of a complete and accurate medical record for each patient. Its content shall be pertinent and current. This record shall include the identification data, medical history, physician examination, annual re-examination, treatment plan and rehabilitation potential, admitting diagnosis, physician orders and progress notes, nursing notes, medication and treatment record, laboratory and x-ray reports, consultation reports, dental reports, physical therapy and occupational therapy records, podiatry records, rehabilitation records, social service histories and summaries, patient referral forms, final diagnosis, dispositions of patient and final discharge.
25. The attending physician or licensed independent practitioner performs each resident's medical assessment, including a medical history and physical examination, within required time frames. This time frame must not exceed 24 hours before admission or within 72 hours after admission. Durable, legible originals or reproductions of a medical history and physical examination, obtained from the attending physician or licensed independent practitioner and completed within 30 days before admission or readmission, are acceptable provided that:
 - there is a summary of the resident's condition and course of care during the interim period; and
 - the summary also includes the current physical/psychosocial status of the resident.

This summary is completed within 24 hours before admission or within 72 hours after admission. If the physician or licensed independent practitioner other than the attending physician performed the assessment that is being transferred and that assessment was performed within 30 days before admission, or within 24 hours

before admission, or within 72 hours after admission, the attending physician or attending licensed independent practitioner must:

- review the physical examination;
- conduct a second assessment to confirm the information and findings;
- update any information and findings as necessary including a summary of the resident's condition and course of care during the interim period and the current physical/psychosocial status;
- sign and date the additional information as an attestation to it being current.

Any previous medical history does not have to be completely redone. It can be updated with information about the most recent illness and hospitalization.

26. Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations should be kept on file in the Health Information Management Department.
27. The patient's medical record will be completed upon discharge according to Article I, Section 3-M, pp. 17-18.
28. A physician's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, be dated and signed by the attending physician.
29. All current and completed records are the property of MercyOne and shall be removed from the facility's jurisdiction and safekeeping only in accordance with a court order subpoena or statute, and nursing home policy.
30. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive such information.
31. Free access to all medical records of nursing home patients shall be afforded to members of the medical staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Hospital President or designee, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all of the period during which they attended such patients in the nursing home.

Section 8. Rehabilitation Unit

1. Medical direction is provided by a physician who is knowledgeable and skilled by training and experience, in rehabilitation medicine services. The Rehab physician will conduct face-to-face visits with the patient at least 3 days per week to assess patient both medically and functionally to maximize the patient's capacity to

benefit from the rehabilitation process.

2. Patients referred to the Rehabilitation Unit will be followed for general medical management by their primary physician or designee unless otherwise specified by the primary physician and documented on the patient record. Other physician specialties may treat and visit the patient, as needed, more often than 3 days per week.
3. The Medical Director of Rehabilitation Services is responsible for the quality of all rehabilitation medical services provided utilizing an interdisciplinary team approach to the delivery of rehabilitation care achieved through periodic team conferences at least once per week.
4. The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment. The treatment plan for each patient has physician participation in both general medical and rehabilitation medical needs of the patient.

Section 9. Students

1. All students shall be sponsored by a member of the Active Medical, Dental or Associate Staff.
2. A request to have a medical, nurse practitioner or physician assistant student accompany a practitioner must be submitted to the Medical Staff Office at least one (1) month prior to the student's expected arrival date. The length of time the student will be at MercyOne shall also be made known at this time.
3. The request shall provide, at a minimum, information regarding:
 - Name of Student
 - Address
 - University attending
 - Year in school
 - Scope of training
 - Expected outcomes of the experience; that is, hands on experience or just observation, etc.
4. The student and sponsoring Medical Staff member shall complete an application form which is available from the Medical Staff Office.
5. The sponsoring Medical Staff member shall submit a statement assuming full responsibility for the student and an agreement to hold harmless the hospital for any and all claims, costs, etc., as a result of any claim or loss that would involve the student.
6. All students shall sign a confidentiality statement prior to any involvement with

patients.

7. All students shall submit written proof of his/her own professional liability insurance with at least minimal limits of \$200,000/\$600,000 if it is intended that the student have any "hands on" patient care.
8. Students shall be allowed to perform "hands on" care based on their year in school and training. This decision to allow students to perform "hands on" care and what that will be, shall be determined and made known to the Medical Staff Office by the sponsoring physician. In the case of surgery activities shall not exceed the following:
 - Hemostasis by clamping, sponging, tying suture and electrocoagulation
 - Retracting
 - Skin closure by suturing or stapling
 - Irrigation and suctioning.
9. The appropriate hospital staff shall be notified when the student is approved.
10. Students shall wear a name tag identifying them as a student and they will perform and dress in an appropriate manner.

ARTICLE II: SPECIAL MEDICAL STAFF COMMITTEES

Section 1. Critical Care Committee

A. Composition:

This committee shall be composed of members of the Medical Staff representing major departments, including Anesthesiology, Surgery, Medicine, Emergency Medicine and Pediatrics. Representatives from Critical Care Nursing Service, Respiratory Care Department, Cardiology, and Cardiac Rehab shall be appointed by hospital administration.

B. Duties:

The multidisciplinary committee assures that the quality, safety, and appropriateness of patient care services provided within the units are monitored and evaluated on a regular basis and that the appropriate actions based on findings are taken. The activities of and direction for the units are guided by a multidisciplinary committee. The chairperson of the committee serves as Director of ICU and Respiratory Care.

C. Meetings:

This committee shall meet at least quarterly. All appointed members shall have the right to vote.

Section 2. Infection Control Committee

A. Composition:

1. Regular committee members shall include the following:
 - a. Infection Control Officer: a practitioner medical staff member who will serve as chairperson of this committee;
 - b. a representative of MercyOne's Executive Staff;
 - c. a nursing representative (may be fulfilled by a member also serving another role);
 - d. laboratory technologist and/or microbiologist;
 - e. infection preventionist;
 - f. a practitioner from Anesthesia, Surgery, Medicine, Pediatrics/Newborn, Obstetrics/Gynecology, and Pathology.
2. Ancillary committee members (housekeeping, central service, laundry, nutrition service department, engineering and maintenance department, pharmacy, operating suite, and materials management are not required to attend each meeting, but are subject to call by the regular membership as needed.

B. Duties:

1. Approves the type and scope of surveillance activities which include definitions and criteria to determine healthcare associated infections (HAI's).
 - a. review of designated microbiological reports,
 - b. review of patient infections and focus attention on those infections that present the potential for prevention or intervention to reduce the risk of future occurrence.
2. Review of surveillance data is directed at identifying unusual epidemics, clusters of infections, infections due to unusual pathogens, and any occurrence of HAI's infection that exceeds the usual baseline levels.
3. Review of prevalence and incidence studies.
4. Approves any routine or special collection of other data (i.e., sampling of personnel or the environment for infective agents).

5. Approves actions to prevent or control infection based on an evaluation of the surveillance reports of infections and of the infection potential among patients and hospital personnel.

C. Meetings:

The committee will meet at least quarterly. Special meetings may be called at the request of the Infection Control Officer and/or infection preventionist. The meeting will be chaired by the Infection Control Officer, or if absent, a physician designee. All regular committee members shall have a right to vote.

Section 3. Nominating Committee

A. Composition:

The Nominating Committee shall consist of the President of the Medical Staff, the Hospital President and selected representative from the Medical Staff Executive Committee who are currently on the Active Medical Staff.

B. Duties:

This committee shall present a list of qualified candidates of nominees for office selected from the Active Staff. Additional nominations may be made from the floor.

C. Meetings:

This committee shall meet at least thirty (30) days prior to the annual meeting of the Medical Staff to recommend a slate of nominees for the election of officers for the ensuing Medical Staff year.

Section 4. Pharmacy and Therapeutics Committee

A. Composition:

Membership shall consist of at least four (4) representatives of the Medical Staff and one (1) each from Pharmaceutical Services, Patient Care Services, Nutrition Services, and from hospital administration.

B. Duties:

This committee shall be responsible for the development and surveillance of drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the

hospital. It shall also perform the following specific functions:

1. serve as an advisory group to the hospital, medical staff and pharmacy on matters pertaining to the choice of available drugs;
2. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
3. develop and review periodically a formulary or drug list for use in the hospital;
4. review bio-equivalency concerns regarding specific generic products;
5. evaluate clinical data concerning new drugs or preparations requested for use in the hospital; and
6. periodically perform "Drug Usage Review" functions as defined by The Joint Commission.

C. Meetings:

This committee shall meet at least quarterly and send quarterly reports to the Executive Committee regarding its activities. Medical Staff representatives and the Pharmacy Clinical Coordinator, or appointed pharmacy department designee, have voting rights.

Section 5. Physical Rehabilitation/Long Term Care Committee

A. Composition

This committee shall be comprised of the Medical Director of the Rehabilitation Unit, Medical Director of Dyersville SeniorCare, in addition to medical staff members from the following specialties: Neurology, Orthopedics, Hospitalist, and a psychologist with Associate Staff status. Lead staff resource for this committee shall be the Director of Patient Care Services (Rehab Unit). Staff representation to this committee shall include: Nursing, Social Services, Nutrition, Case Manager, Director of PM/R Services, Respiratory Care, Pharmacy, and administrative representation.

B. Duties

It shall be the duties of this committee to review safety, infection reports, utilization review, quality improvement activities, and serve as consultation for the rehabilitation skilled nursing units and MercyOne Dyersville Senior Care.

C. Meetings

The committee shall meet at least quarterly and all regular members of this committee shall have the right to vote.

Section 6. Trauma Service Committee

A. Composition:

This committee, at a minimum, shall be composed of all trauma surgeons; representatives from Emergency Medicine, Anesthesia, Orthopedics, and Rehabilitation; the Director of the Emergency Department; the Trauma Program Manager; and representatives from Administration and Nursing. The Trauma Medical Director will report to the president of the Medical Staff.

B. Duties:

Examine and improve trauma-related hospital operations. Create, review, update and approve trauma-related protocols. Conduct Performance Improvement and Patient Safety (PIPS) review.

C. Meetings:

Trauma Committee meetings are held bi-monthly. Included within these meetings is the multidisciplinary trauma performance improvement program where cases are presented, care is evaluated across disciplines, opportunities for improvement are identified, and corrective actions are implemented. All members have the right to vote.

Section 7. Tumor Registry Committee:

A. Composition:

This committee shall be composed of all medical and radiation oncologists; representatives from the Radiology Department; Departments of Medicine, Surgery, Obstetrics and Gynecology, and Pathology; and surgical subspecialties of Urology and Otolaryngology.

B. Duties:

This committee will present case presentations at their meetings on a preassigned basis and will be responsible for helping maintain the Tumor Registry through cooperation of the Medical Records Department.

C. Meetings:

This committee shall meet at least monthly. All physician members have the right to vote.

MERCYONE DUBUQUE MEDICAL CENTER
DUBUQUE, IOWA
FAIR HEARING AND APPELLATE REVIEW MANUAL
AND
RELATED DOCUMENTS

ARTICLE XII OF THE BYLAWS

REVISIONS APPROVED by MercyOne Dubuque Medical Center Medical Staff 2019

REVISIONS APPROVED by MercyOne Dubuque Medical Center Board of Trustees 2019

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FAIR HEARING PROCEDURES

ARTICLE I

APPLICATION OF REVIEW PROCEDURES

1.1 SCOPE

This Plan provides methods for review, hearing, and appeal of certain types of recommendations made or actions taken with respect to Staff membership and/or clinical privileges. Two types of formal hearings are provided: basic and special. A "basic hearing" is a hearing conducted by the Executive Committee, a subcommittee of the Executive Committee or committee appointed by the Board and uses simplified rules of procedure (article III). A "special hearing" is conducted by a specially appointed ad hoc committee or a hearing officer (Article IV). An Affected Practitioner is entitled to only one type of hearing; the selection of the type of hearing is determined by the nature of the recommendation or action involved.

1.2 DEFINITIONS

The following definitions shall apply to this Plan:

"Administration" means the executive and administrative organization of the Hospital.

"Affected Practitioner" means a Staff Member or Initial Applicant as to whom a Staff or Board recommendation was made or action taken.

"Board" means the Divisional Board of the Hospital.

"Bylaws" mean the Bylaws of the Staff.

"Hospital President" means the President of the Hospital or a person from Administration designated in writing to act on his/her behalf for the purpose of hearing proceedings under this Plan.

"Executive Committee" means the Executive Committee of the Staff.

"Initial Applicant" means a physician, dentist, or other qualified health care professional making application for initial appointment to the Medical-Dental Staff.

"PMS" means the President of the Medical Staff.

"Special Notice" means written notification by registered mail or certified mail, return receipt requested, or personal delivery by a Hospital employee designated by the Hospital President, subject to 5.8.

"Staff" means the organized Medical-Dental Staff of the Hospital.

"Staff Member" means a physician, dentist, or other qualified health care professional who is a member of the Staff.

1.3 WHEN BASIC OR SPECIAL HEARING PROCEDURES DO NOT APPLY

When the formal (basic or special) hearing procedures delineated in this Plan do not apply to a recommendation or action, any Medical-Dental Staff or Initial Applicant member who believes he/she is aggrieved by any such action or recommendation of the Executive Committee or Board may seek review of the action or recommendation by submitting a written statement taking exception to such action or recommendation and specifying the reasons therefor. The statement shall be read or furnished to whichever body made the recommendation or took the action, and made a part of the Staff Member's or Initial Applicant's permanent file. The statement may also request an opportunity to appear before the Executive Committee or Board to informally discuss his/her position on the action, which request may be granted in the discretion of the Executive Committee or Board. After review the Board may also, in its sole discretion, direct a basic or special hearing be held (even though one is not required), to review and make recommendations concerning the underlying matter at issue.

ARTICLE II

ADVERSE RECOMMENDATION OR ACTION

2.1 NOTICE OF RECOMMENDATION OR ACTION

When a recommendation is made or action taken by the Executive Committee or the Board which, according to this Plan, entitles an Affected Practitioner to a basic hearing (3.1) or special hearing (4.1) prior to a final decision of the Board on that recommendation or action, the Affected Practitioner shall be promptly given Special Notice by the Hospital President. This Special Notice shall contain:

- (a) A statement of the recommendation made and the general reasons for it;
- (b) A statement that the Affected Practitioner has the right to request a hearing on the recommendation within thirty (30) days of his receipt of the notice;
- (c) A statement of the kind of hearing (basic or special) to which the Affected Practitioner is entitled; and
- (d) A copy of this Plan, unless it has already been provided to the Affected Practitioner.

2.2 REQUEST FOR HEARING

The Affected Practitioner shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing. The request shall be made in writing and delivered in person or by certified mail to the Hospital President.

2.3 WAIVER BY FAILURE TO REQUEST A HEARING

An Affected Practitioner who fails to request a formal hearing within the time and in the manner specified in 2.2 waives any right to such hearing and to any possible appellate review. When such waiver is in connection with:

- (a) A proposed or actual adverse action by the Board, it shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board;
- (b) An adverse recommendation or action by the Executive Committee, it shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. In this event, the Board shall consider the Executive Committee's recommendation at its next regular meeting following waiver. In its deliberations, the Board shall review and consider the recommendation and supporting documentation of the Executive Committee and may consider any other relevant information received from any source. The Board's action on the matter shall constitute the final decision of the Board.

ARTICLE III

BASIC HEARING PROCEDURES

3.1 APPLICATION OF BASIC HEARING PROCEDURES

The basic hearing procedures as set forth in Article III of this Plan shall apply to the following recommendations or actions:

- (a) Automatic suspension of Staff Membership or clinical privileges due to loss of licensure; limitations of privileges imposed by governmental prescribing authorities; or conviction of any felony or any crime arising out of professional practice.
- (b) Denial of a request by an active, associate, dental, affiliate or emergency category member to obtain clinical privileges which are not ordinarily possessed by professionals of like training, experience, Staff category and Staff Membership duration.
- (c) Denial of a requested change in Staff category.

- (d) Issuance of a letter of reprimand without any reduction or limitation on the exercise of clinical privileges.
- (e) Imposition of a consultation requirement of more than thirty (30) days, or the extension of provisional status greater than sixty (60) days.
- (f) Non-reappointment to the Staff by reason of failure to document financial responsibility/professional liability insurance requirement compliance. (However, a hearing based on this action shall be limited to the issue of whether financial responsibility compliance has been documented by the Staff Member.)

3.2 NOTICE OF TIME AND PLACE FOR HEARING

Upon receipt of a timely and proper request for a basic hearing, the Hospital President shall, after consultation with PMS or the Board, depending on the body whose recommendation or action prompted the request for hearing, promptly schedule and arrange for the hearing. At least seven (7) days prior to the hearing date, the Hospital President shall notify the Affected Practitioner of the date, time, and place of the commencement of the hearing by Special Notice. The hearing date ordinarily should not be less than thirty (30) days nor more than forty-five (45) days from the date of receipt of the request for hearing.

3.3 STATEMENT OF REASON

If the reason(s) for the action or recommendation have not already been stated to the Affected Practitioner, he/she may request that such reasons be provided in his/her request for hearing. Such a request for reasons shall be responded to by letter from the Hospital President, mailed or delivered to the Affected Practitioner at least three (3) days before the scheduled date for the hearing. The statement of reasons may be amended at any time, provided the Affected Practitioner is given a reasonably sufficient opportunity to prepare to meet any added reasons.

3.4 APPOINTMENTS OF HEARING COMMITTEE

3.4-1 By Medical Staff. A hearing occasioned by recommendation of the Executive Committee shall be conducted by:

- (a) A quorum of the Executive Committee or
- (b) A subcommittee of no less than three members, active, dental, and/or associate staff, at least one of which persons must be a member of the Executive Committee, appointed by the PMS to conduct the hearing.

The PMS, who shall not be a member of the committee, shall appoint a member of the committee to serve as its chair.

3.4-2 By Board. A hearing occasioned by adverse action of the Board shall be conducted by a hearing committee appointed by the Board. This committee shall be composed of not less than three members, at least one of whom shall be a physician or dentist. The Chairperson of the Board, who shall not be a member of the hearing committee, shall designate a member of the committee to serve as its chair.

3.4-3 Service on Hearing Committee. A Staff or Board member shall not be disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter at issue or because of knowledge of facts involved. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity.

3.4-4 Notice to Affected Practitioner. The Hospital President shall notify the Affected Practitioner of the hearing committee's composition.

3.5 APPEARANCE AND REPRESENTATION

3.5-1 Appearance of Affected Practitioner. The Affected Practitioner requesting the hearing must be present for the hearing; his/her failure to appear at the date and time set forth in the notice and proceed with the hearing shall constitute a waiver of the right to a hearing. Under extenuating circumstances, the Affected Practitioner may request written permission for delay in the hearing from the PMS, or his/her designee.

3.5-2 Representation. At any basic hearing:

(a) The Affected Practitioner shall represent him/herself.

(b) If the hearing committee is the Executive Committee or a subcommittee thereof, the PMS may, in his/her discretion, appoint him/herself or another Staff Member to represent the position adverse to the Affected Practitioner.

(c) If the hearing committee is a committee appointed by the Board, the Chairperson of the Board may, in his/her discretion, appoint a person to represent the position adverse to the Affected Practitioner.

(d) A person assigned to represent the interest adverse to the Affected Practitioner shall be called the "Advocate."

(e) Neither the Affected Practitioner nor the Advocate may participate in deliberations of the hearing committee.

3.6 HEARING CONDUCT AND EVIDENCE

3.6-1 Hearing Conduct. The chairperson of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence.

The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the considerations of evidence. The presiding officer may also promulgate hearing rules consistent with 5.4.

The hearing shall be conducted in such a manner that both the Affected Practitioner and the Advocate, if any, has an opportunity to have his/her position fairly heard and considered. Members of the hearing committee may ask questions of the Affected Practitioner and the Advocate, if any.

3.6-2 Evidence. The Affected Practitioner and the Advocate may submit to the hearing committee for consideration:

(a) Written statements, letters and documents, which are relevant to the subject matter of the hearing, including relevant portions of the file maintained by the Hospital regarding the Affected Practitioner.

(b) Oral statements by the Affected Practitioner and the Advocate (if any).

(c) Only when deemed essential to a meaningful hearing, the presiding officer may, in his/her discretion, authorize the appearance, examination and cross-examination of witnesses, consistent with supplemental hearing rules; unless, so authorized, neither the Affected Practitioner nor the Advocate shall have a right to present witnesses, or cross-examine in person.

Evidence admitted in the hearing need not strictly meet the requirements of admissibility of a court of law, and the hearing committee may consider any evidence customarily relied upon by responsible persons in the conduct of serious affairs.

3.7 BURDEN OF PROOF

The Affected Practitioner shall have the burden of proof and must demonstrate that the action or recommendation is:

(a) Arbitrary;

(b) Capricious; and/or

(c) Based on inaccurate or insufficient information through no fault of the Affected Practitioner.

3.8 RECORDING OF HEARING

The hearing shall be recorded by minutes prepared by a recording secretary selected by the Hospital President, which minutes shall be subject to approval and amendment by the hearing committee. Other means of recording (e.g., electronic tape or court stenographer) shall be used only at the request or with the consent of the hearing committee.

3.9 RECOMMENDATION

3.9-1 Notice. Within thirty (30) days after completion of the hearing, the hearing committee shall meet, deliberate, and then issue its report in writing to the Hospital President. The report shall be submitted by the Hospital President to the PMS or Board (as appropriate), the Advocate (if any), and to the Affected Practitioner (by Special Notice).

3.9-2 Action on Recommendation.

- (a) If the hearing committee was a subcommittee of the Executive Committee, its report shall be submitted to the Executive Committee for consideration. Thereafter, the Executive Committee shall make its final recommendation, subject to approval by the Board.
- (b) If the hearing committee was the Executive Committee as a whole, the hearing committee report shall become the final recommendation of the Executive Committee, subject to Board action.
- (c) If the hearing committee was one appointed on behalf of the Board, its report shall become its final recommendation, subject to Board action. If timely requested, final Board action may be subject to reconsideration on appeal.

3.10 APPEAL

If, following a basic hearing pursuant to this Article, the Affected Practitioner believes that the hearing committee's recommendation was arbitrary, capricious, or lacks any evidence in support, which shall be the sole grounds for appeal, he/she may, within fifteen (15) days of receipt of notice of the recommendation, submit a written appeal of the recommendation consisting of not more than ten (10) pages of text (not including exhibits) concisely stating the basis therefor to the Hospital President. If such an appeal is filed, the hearing committee, a representative thereof, or the Advocate, if any, may submit a written response in opposition within fifteen (15) days after the appeal is received. The appeal shall be considered by the Board which shall, within forty-five (45) days after receipt of the appeal, take one of the following actions:

- (a) Refer the matter back to the hearing committee for further review or supplemental findings; if this is done, the hearing committee shall respond in writing to the Board request within fifteen (15) days of request, and the Board shall then take the actions in (b), (c), or (d) below within thirty (30) days after receipt of the response; or
- (b) Uphold the recommendation of the hearing committee and take final action accordingly; or
- (c) Reverse or modify the recommendation of the hearing committee with or without the requirement that further hearings be conducted by the hearing committee; or

- (d) Reverse or modify the recommendation of the hearing committee and require a special hearing be held in accordance with the provisions of Article IV of this Plan.

The Hospital President shall advise the Affected Practitioner in writing, by Special Notice of the outcome of the appeal.

ARTICLE IV

SPECIAL HEARING PROCEDURES

4.1 APPLICATION OF SPECIAL HEARING PROCEDURES

The special hearing procedures as set forth in Article IV of this Plan shall apply to the following recommendations or actions:

- (a) Non-reappointment to the Staff, except when because of: failure to timely submit a re-credentialing form; or to document financial responsibility; or timely request for reinstatement following the expiration of leave of absence.
- (b) Denial, involuntary reduction or suspension of clinical privileges of active, associate, dental, affiliate or emergency category member which are ordinarily possessed by Staff members of like or similar training and Staff duration, for fifteen (15) days or more;
- (c) Revocation or suspension of Staff Membership except when because of failure to timely submit a re-credentialing form; or to document financial responsibility; or to timely request reinstatement following expiration of a leave of absence.
- (d) Denial of an initial application for appointment to the Staff, except when because of the application being incomplete; the application containing material inaccuracies; or any reason unrelated to the competence or professional conduct of the Initial Applicant;
- (e) Such other recommendations or actions as the Board may direct in its discretion, after consultation with the Executive Committee.

4.2 TIME AND PLACE FOR HEARING

4.2-1 Scheduling the Hearing. Upon the receipt of a timely and proper request for a special hearing, the Hospital President shall promptly schedule and arrange for the hearing. The hearing date shall ordinarily be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing.

4.2-2 Shortened Time Limit for Hearing. A hearing for a Staff Member who is under suspension then in effect may be held in less than thirty (30) days after the request is made, provided such Staff Member's request for the hearing includes a specific request that the hearing be

held in less than thirty (30) days; in the event such a special request for a shorter period is made by a Staff Member who is under suspension, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and requirements for same met, subject to 4.3 below.

4.2-3 Lengthened Time Limit for Hearing. If the Affected Practitioner objects to the composition of an ad hoc hearing committee, or a determination is made that an alternate hearing officer shall conduct the hearing, the sixty (60) day maximum limitation shall be deemed waived by the Affected Practitioner. In such event, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and the requirements for same met. The Hospital President shall advise those involved in the hearing process of changes necessitated by such objections.

4.3 HEARING NOTICE, RESPONSE AND WITNESS LISTS

4.3-1 Hearing Notice. The Hospital President shall issue a notice of hearing by Special Notice to the Affected Practitioner and by any suitable means of notice to others involved in the hearing process. The notice of hearing shall specify:

- (a) Time and Location – The scheduled date, scheduled time and location of the hearing, as well as a statement of reasons and list of witnesses.
- (b) Statement of Reasons – As applicable, a statement of the alleged acts or omissions of a Staff member, a list by number of the specific or representative patient charts in question and/or other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.
- (c) List of Witnesses – A list of witnesses, if any, that the body which took or proposed adverse action (or its designated representative) believes will be called as witnesses to testify in support of the recommendation or action at the time of the hearing.

4.3-2 Response and List of Witnesses of Affected Practitioner. Within fourteen (14) days after receipt of the notice of hearing, the Affected Practitioner shall furnish to the Hospital President his/her written response to the Statement of Reasons and a list of the individuals (and their addresses) who may or will be called as witnesses in support of the Affected Practitioner's position at the time of the hearing.

4.3-3 Amendments. The statement of reasons, the response, or the list of witnesses of either party may be amended at any time by the party furnishing them, provided that the opposite party is given a reasonable period in which to prepare to meet the substance of the amendments to the statement of reasons or the substance of testimony of additional witnesses. For the purpose of this provision, a time period of one week or more shall be presumed to be a "reasonable period." The permissibility of a shorter period of notice shall be subject to the discretion of the presiding officer for the hearing.

4.4 APPOINTMENTS TO HEARING COMMITTEE

4.4-1 Hearing Committee, Presiding Officer and Notice.

- (a) The Hospital President, acting for the Board, after considering the recommendations of the PMS (and that of the Chairperson of the Board, if the hearing is occasioned by a Board determination) shall appoint a hearing committee which shall generally be composed of not less than three members. The committee shall be composed of Staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level, or of physicians or lay persons not connected with the Hospital or a combination of such persons. The committee shall not include any individual who is in direct economic competition with the Affected Practitioner or any individual who is professionally associated with or related to the Affected Practitioner.
- (b) Designation shall also be made of the presiding officer of the hearing committee who may, but need not be a voting member of the committee, e.g., an attorney may be appointed as presiding officer to participate in committee deliberations and assist in the preparation of the hearing committee report, but not have a vote for or against adoption of the final hearing committee report. The appointments are subject to the further requirements and procedures of this section.
- (c) Notice of the hearing committee composition shall be given, either as part of the Notice of Hearing or by late Special Notice to the Affected Practitioner.

4.4-2 Service on Hearing Committee. A Staff Member or other person appointed to serve on an ad hoc hearing committee shall not be disqualified from serving on a hearing committee merely because of knowledge of the underlying facts or because of participation in an earlier hearing involving the same Affected Practitioner. However, if after objection timely submitted, the Hospital President, in his/her good faith discretion, determines that there is reasonable evidence to support the conclusion that a proposed member of the hearing committee is either in direct economic competition with the Affected Practitioner or could not decide the matter with good faith objectivity, the proposed member of the hearing committee shall be removed and, as appropriate, replaced before the hearing.

4.4-3 Questions to Hearing Committee. Within seven (7) days after the Affected Practitioner is given notice of those who are proposed to serve on the hearing committee, the Affected Practitioner shall be entitled to submit reasonable written questions of not more than ten (10) in number limited to the issues of direct economic competition or bias to all or any one or more of the proposed hearing committee members through the Hospital President. The Hospital President shall, in his/her good faith discretion, determine whether questions are reasonable and relevant to the issues of direct economic competition or bias, and shall strike such questions which are unreasonable or irrelevant. The questions, except those which are deemed by the Hospital President to be unreasonable or irrelevant, will then be submitted to the proposed hearing committee member(s) to whom directed, who shall then submit his/her response(s) within thirty (30) days to the Hospital President. The Hospital President shall in turn forward the answers on a prompt basis to the Affected Practitioner

and the PMS or Board Chairperson, depending upon the body which took the action or made the recommendation which is the subject of the hearing.

4.4-4 Objections to Proposed Hearing Committee Members. Within seven (7) days after receipt of notice of the proposed hearing committee membership or, if the procedure set forth in 4.4-3 was elected by the Affected Practitioner, seven (7) days after his/her receipt of the responses to the written questions, the Affected Practitioner shall be entitled to submit his/her written objections, if any, to those proposed members of the hearing committee which he/she believes are in direct economic competition with him/her or are so biased against him/her as to prevent a fair hearing if they serve as a hearing committee member. Such objections, if any, will be reviewed by the Hospital President who shall determine in his/her good faith discretion as to whether or not the objections are meritorious.

(a) If none of the objections are deemed to be meritorious by the Hospital President, he/she shall so advise the Affected Practitioner, in writing, and the hearing committee shall be constituted in the manner proposed.

(b) If the Hospital President determines that the objections to any or all of the hearing committee membership have substance, he/she shall confer with the PMS or the Chairperson of the Board, depending upon the body whose recommendation or action is the subject of the hearing, as to possible alternative proposed members of the hearing committee.

(1) If the PMS or Chairperson of the Board believes that there are other alternative persons who may satisfactorily meet the requirements of membership on the hearing committee, the process set forth in 4.4-3 and this 4.4-4 regarding written questions and objections, shall be repeated as necessary until an appropriate hearing committee can be constituted.

(2) If, however, the PMS or Chairperson of the Board believes that there is no person available at the Hospital or in the community, who meets the committee membership requirements for participation on a hearing committee, the requirements of 4.4-1 shall not apply.

4.4-5 Alternate Hearing Officer. If by reason of objections to proposed membership which are determined to be valid by the Hospital President, a hearing committee of at least three (3) volunteer persons as provided in 4.4-1 cannot be constituted, the Hospital President shall be empowered to appoint a single person to serve as hearing officer (who may, but need not be a Staff Member), where:

(a) In the good faith discretion of the Hospital President, such person is not in direct economic competition with, and has no known bias towards the Affected Practitioner; and

(b) The Hospital President has consulted with the Affected Practitioner and the PMS or Board Chairperson (depending upon which body prompted the hearing) regarding the

appointment of such person and the Hospital President has, in his/her good faith discretion, taken into account the legitimate objections, or preferences of the Affected Practitioner and the PMS or Board Chairperson as well as the availability of a qualified person to serve as hearing officer.

- (c) As a part of the appointment process, in lieu of consultation provided in (b) above, the Hospital President may, in his/her sole discretion, provide the Affected Practitioner and the PMS or Board Chairperson with a list, by name, of two (2) or more prospective hearing officers from which one (1) person may be appointed by the Hospital President to serve as hearing officer. If submitted, the Affected Practitioner and the PMS or Board Chairperson may submit objections and the reasons in writing to the Hospital President within seven (7) days of receiving the list. If objections are timely made and meritorious in the judgment of the Hospital President, this process may be repeated until a mutually satisfactory hearing officer can be selected or the procedures of (b) above utilized.

4.4.-6 Notice of Appointment of Hearing Officer. Notice of the appointment of a hearing officer shall be promptly given to the Affected Practitioner. Such notice shall include the estimated fee and expenses of the hearing officer, if any.

- (a) If a fee and expenses are required by the hearing officer for his/her services as such, the cost will be equally borne by the Hospital and the Affected Practitioner and in advance one-half of the estimated costs shall be sent to the hearing officer by the Affected Practitioner within fourteen (14) days from notice of the hearing officer's appointment.
- (b) If, and only if, the Affected Practitioner who requested the hearing can demonstrate such poverty that he/she is unable to pay his/her portion of the hearing officer's fee, if any, the entire fee for the officer shall be borne by the Hospital. However, in order to establish this poverty sufficient to relieve the Affected Practitioner of his/her obligation to pay half the fee and expenses for such hearing officer, the Affected Practitioner must provide, upon request, financial information which the Hospital President deems necessary to make the determination including personal and business income tax returns for the preceding two (2) years, financial statements prepared regarding his/her practice (including any professional corporation or partnership owned in whole or in part by him/her) and a statement of assets under oath.

4.4-7 Substituted Reference to Hearing Officer. In the event a hearing officer is appointed instead of a hearing committee, all references in this Article to the "hearing committee" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly otherwise required.

4.4-8 Waiver of Rights. In the event the Affected Practitioner fails to, within seven (7) days after notice, timely submit written questions or raise objections to proposed members of the hearing committee or to a proposed alternate hearing officer, he/she shall be deemed to have waived his/her right to submit such questions and/or make objections to the

composition of the hearing committee or the selection of an alternate hearing officer. Further, a failure of the Affected Practitioner to timely submit financial information upon request to the Hospital President necessary to establish a claim of poverty with regard to payment of the hearing officer, shall constitute a waiver of any right to have the Hospital pay the full amount of a hearing officer's fee. The failure to timely submit one-half of the estimated fees and expenses of a hearing officer, if one is appointed, shall be deemed to be a waiver of the right to any hearing, unless an exception based on poverty is granted. In addition, the failure of the Affected Practitioner to pay his/her share of the finally determined fees of the hearing officer, after the hearing, shall result in the withholding of any clinical privileges the Affected Practitioner holds, until such obligation is paid.

4.5 PERSONAL PRESENCE

The personal presence of the Affected Practitioner shall be required. An Affected Practitioner who fails without good cause to appear and to proceed at such hearing shall be deemed to have waived such rights in the same manner and with the same consequence as provided in 2.3 and 5.2.

4.6 PRESIDING OFFICER

The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present appropriate oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on the matters of law, procedure, and the considerations of evidence. If the hearing is conducted by a single hearing officer as provided in 4.4, he/she shall serve as the presiding officer.

4.7 REPRESENTATION AND APPOINTMENT OF ADVOCATE

The Affected Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Staff in good standing or by a member of his/her local professional society. The Executive Committee or Board, as may be applicable, shall appoint a person to present the facts in support of its adverse recommendation referred to as the "Advocate." The Advocate may present evidence but, even if an Executive Committee or Board member, shall not participate in deliberations nor vote on the matter at issue. Representation of either party by an attorney at law shall be governed by the provisions of 5.1.

4.8 RIGHTS OF PARTIES

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

- (a) Call and examine witnesses;
- (b) Cross-examine witnesses called by the other party;

- (c) Introduce exhibits;
- (d) Question witnesses on matters relevant to the issues; and
- (e) Rebut any evidence.

If the Affected Practitioner does not testify, he/she may be called and examined as if under cross-examination.

4.9 PROCEDURE AND EVIDENCE

The hearing will not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party may, prior to, during, at the close of or if specifically requested and authorized by the presiding officer, within seven (7) days of the hearing, be entitled to submit an additional memoranda concerning any issue of procedure, fact, or conclusions drawn from fact, and such memoranda shall become part of the hearing record. The presiding officer may, but shall not be required, to order that oral evidence be only taken on oath or affirmation.

4.10 MATTERS CONSIDERED

In addition to relevant evidence formally presented at the hearing, the hearing committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information which can be considered in connection with applications for appointments or reappointments to the Staff and a request for clinical privileges. In this respect, to facilitate the hearing efficiency, subject medical charts, investigative reports, pertinent correspondence, committee minutes, and the statement of reasons, may be furnished by the Hospital President in his/her discretion, to the hearing committee provided the Affected Practitioner is advised same have been furnished to the hearing committee and may challenge its relevancy at the hearing. The hearing committee shall be entitled to conduct independent review research and interviews, or retain an independent consultant to do so, but may utilize the products of such in its decision, only if the Affected Practitioner and the Advocate are aware of such, and have an opportunity to rebut any information so gathered.

4.11 BURDEN OF PROOF

The Advocate shall have the initial obligation to present evidence in support of the subject recommendation or action. The Affected Practitioner shall thereafter be responsible for supporting a challenge to the adverse recommendation or action by convincing evidence that:

- (a) The grounds therefor are not supported by the evidence; or
- (b) The conclusions drawn therefrom are arbitrary or capricious.

4.12 RECORD OF HEARING

A record of the hearing shall be made by a certified court stenographer (reporter). The Affected Practitioner shall be entitled to a copy of the record upon payment of the costs for a duplicate copy.

4.13 DELIBERATIONS AND RECOMMENDATION OF THE HEARING COMMITTEE OR HEARING OFFICER

4.13-1 Deliberations. Upon conclusion of the presentation of evidence, the hearing shall be closed. Within thirty (30) days thereafter, the hearing committee, outside the presence of any other person, shall conduct deliberations and consider the admitted evidence.

4.13-2 Contents of Report. The hearing committee shall prepare a report which shall contain a concise statement of recommendations and the reasons justifying the recommendations made. This report shall be delivered to the Hospital President.

4.14 DISPOSITION OF HEARING COMMITTEE REPORTS

Upon its receipt, the Hospital President shall forward the hearing committee report and recommendation, along with all supporting documentation, to the Board for further action. The Hospital President shall also send a copy of the report and recommendation by Special Notice to the Affected Practitioner. A copy of the report of the hearing shall be delivered by the Hospital President to anybody other than the Board that made the adverse recommendation for informational purposes.

4.15 NOTICE AND EFFECT OF RESULTS

4.15-1 Effect of and Action Upon Favorable Hearing Committee Report. If the hearing committee's report pursuant to 4.13 is favorable to the Affected Practitioner, the Hospital President shall promptly forward it, together with all supporting documentation, to the Board for its final action.

- (a) The Board may, before taking final action thereon, refer the matter back to the hearing committee or the Executive Committee for further consideration for information. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing or other review be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action.

(b) If the Board's action on the matter is favorable to the Affected Practitioner it shall become the final decision of the Board, and the matter shall be closed.

(c) If the Board's action would result in any of the recommendations or actions listed in 3.1 or 4.1, the Special Notice shall inform the Affected Practitioner of a right to request an appellate review by the Board as provided in 4.18 of this Plan, as if the hearing committee's report has been adverse. In such circumstances, the Board's tentative position adverse to the Affected Practitioner shall be represented by a person, selected by the Chairperson of the Board for appellate review. All references in 4.16 through 4.26 of this Plan to the "hearing committee" would instead refer to the Board, as the context requires.

4.15-2 Effect of Adverse Hearing Committee Report. If the report and recommendation of the hearing committee pursuant to 4.13 is adverse to the Affected Practitioner in any of the respects listed in 3.1 or 4.1, Special Notice shall be given of the report and recommendation and his/her right to request appellate review by the Board as provided in 4.16 of this Plan.

4.16 REQUEST FOR APPELLATE REVIEW

An Affected Practitioner shall have ten (10) days following receipt of a notice pursuant to 4.15-1(c) or 4.15-2, to file a written request for an appellate review. Such request shall be delivered to the Hospital President either in person or by certified mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, which was considered in making the adverse action or result.

4.17 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

An Affected Practitioner who fails to request an appellate review within the time and in the manner specified in 4.16 waives any right to such review. Such waiver shall have the same force and effect as that provided in 2.3 and 5.2 of this plan.

4.18 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the Hospital President shall deliver such request to the Board. The Board shall schedule and arrange for an appellate review which shall be not more than forty-five (45) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Staff Member who is under a suspension then in effect shall be held as soon as the arrangements and preparations for it may reasonably be made.

The Hospital President shall send the Affected Practitioner notice of the time, place, and date of the review. The time for the appellate review may be extended by the Board for good cause.

4.19 APPELLATE REVIEW BODY

The Board shall be the appellate review body; one Board member shall be designated as Chairperson of the appellate review proceedings.

4.20 NATURE OF APPELLATE REVIEW PROCEEDINGS

The appellate review proceedings of the Board shall be an appellate review based solely upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The Board shall also consider the written statements as may be presented and accepted under this Article.

4.21 WRITTEN STATEMENTS

The Affected Practitioner shall submit a written statement detailing those findings of fact, conclusions and procedural matters with which he/she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Board through the Hospital President at least five (5) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Executive Committee, or if Board action is being appealed, the person selected by the Board to take the position adverse to the Affected Practitioner. If submitted, the Hospital President shall provide a copy thereof to the Affected Practitioner at least two (2) days prior to the scheduled date of the appellate review.

4.22 PRESIDING OFFICER

The Chairperson of the appellate review proceedings shall be presiding officer for any appellate hearing and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

4.23 ORAL STATEMENT

The Board in its sole discretion may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. The maximum time for such statements will be fifteen (15) minutes. Any party or representative so appearing shall be required to answer questions put by any member of the Board.

4.24 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

Subject to 5.4 below, new or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in his/her record shall be introduced at the appellate review only under unusual circumstances. The Board, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

4.25 RECESSES AND ADJOURNMENT

The Board 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 the conclusion of oral statements, if allowed, the proceedings shall be closed. The Board shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared adjourned.

4.26 ACTION TAKEN BY BOARD ON APPEAL

The Board may affirm, modify or reverse the adverse result or action taken by the hearing committee or officer pursuant to 4.13 or 4.15, or, in its discretion, may refer the matter back to the hearing committee or officer for further review and recommendation to be returned to it within forty-five (45) days and in accordance with its instructions. Within fifteen (15) days after receipt of such recommendation after referral, the Board shall make its final decision.

4.27 FINAL BOARD ACTION AFTER APPELLATE REVIEW

Unless the matter is referred back to a hearing committee or officer pursuant to 4.26, within fifteen (15) days after the conclusion of the appellate review, including referrals back to the hearing committee or officer, the Board shall render its decision in the matter in writing and shall send notice thereof to the Affected Practitioner by Special Notice, to the PMS, and to the Executive Committee.

4.28 HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

Those actions or recommendations which entitle an Affected Practitioner to a special hearing pursuant to Article IV are those matters the Hospital and Staff reasonably believe represent "professional review action" and "professional review activity" which may "adversely affect" a "physician" pursuant to the Health Care Quality Improvement Act of 1986. In this respect, it is the intent and purpose of this Plan that the initiation and conduct of professional review actions hereunder comply with all material respects with the provisions of §412 of the Act.

ARTICLE V

GENERAL PROVISIONS APPLICABLE TO BASIC AND SPECIAL HEARINGS

5.1 ATTORNEYS

5.1-1 The Parties

- (a) Basic Hearings. If the Affected Practitioner desires to be represented by an attorney at any basic hearing or at any appellate review pursuant to the provisions of Article III of this Plan, the request for such hearing or appellate review must so state. The hearing committee or appellate review body shall, in its sole discretion, determine whether to permit such representation at the hearings. If and only if it allows the Affected Practitioner to be so represented, the Executive Committee or the Board may also be represented by an attorney at the hearing.
- (b) Special Hearings. If the Affected Practitioner desires to be represented by an attorney at any special hearing or at any appellate review appearance pursuant to the provisions of Article IV of this Plan, the request for such hearing or appellate review must so state. The Affected Practitioner shall have an unqualified right to be represented by an attorney at any such special hearing or appellate review appearance. If the Affected Practitioner chooses to be so represented, the Executive Committee or the Board may also be represented by an attorney at the hearing.

Notwithstanding the foregoing, an attorney may be contacted at appropriate times during the proceedings by any party for advice, provided such contact does not unduly interfere with the conduct of a hearing as determined by the presiding officer.

5.1-2 The Hearing of Appellate Review Body or Administrator. A hearing or appellate review body may, in its discretion, consult with legal counsel at any stage of the proceedings for advice on appropriate hearing conduct or the drafting of its report(s). Hospital counsel may serve as counsel to the Hospital, the hearing committee and the Advocate in the same proceeding.

5.2 WAIVER

If at any time after receipt of Special Notice of an adverse recommendation, action or result, an Affected Practitioner fails to make a required request or appearance or otherwise fails to comply with this Plan, the Affected Practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights under the Bylaws then in effect or under this Plan with respect to the matter involved.

5.3 INDEPENDENT CONSULTANTS

At any stage of hearing proceedings, a hearing committee or the Board may retain an independent consultant, who may or may not be a member of the Staff. The consultant may be provided with medical records, films, slides, reports, or such other materials he/she and the requesting body may deem appropriate for his/her review. The consultant shall present a written or oral report to the requesting body which shall be made available to the parties. A consultant so elected should not be deemed a witness for any of the parties, but an independent advisor whose opinions represent evidence which may be considered.

5.4 SUPPLEMENTAL HEARING RULES

The presiding officer of any hearing or appellate review body may promulgate, with or without the advice of legal counsel, hearing rules to supplement those contained in this Plan. Such rules shall be fundamentally fair to all parties and generally consistent with the provisions of this Plan. The supplemental rules may set forth order of presenting evidence and oral statements as well as time limits for presentations. When feasible, the presiding officer may in his/her discretion arrange a pre-meeting with the parties (or their representatives) to decide upon such rules or ask the parties (or their representatives) to meet and propose rules subject to his/her approval. When such rules are promulgated by the presiding officer, they shall be furnished to the parties before the hearing. Written objections by any of the parties shall be considered and, when deemed meritorious, amendments shall be made in the rules to address the objections.

5.5 NUMBER OF REVIEWS

Notwithstanding any other provision of the Bylaws or of this Plan, no Affected Practitioner shall ever be entitled as a right to more than one hearing and appellate review with respect to an adverse recommendation or action. Further, the Executive Committee and the Board need not conduct additional hearings or reviews upon reapplication or request for reconsideration by an Affected Practitioner, absent a clear and convincing indication of new or additional information which has a substantial probability of changing the outcome of the previous hearing or appeal.

5.6 RELEASE

By requesting a hearing or appellate review under this Plan, the Affected Practitioner agrees to be bound by the provisions of the Bylaws, Rules and Regulations, and this Plan, in all matters relating thereto.

5.7 ADJOURNMENTS AND TIME LIMIT MODIFICATION

Any procedural rule or time limit specified in this Plan may be modified or waived by agreement between the presiding officer of the hearing committee and the Affected Practitioner, or a duly authorized designate of either. The Board, the presiding officer or a hearing committee may use discretion on granting an extension of any time limits when required for fundamental fairness to any party, to obtain new evidence or for consultation. An Affected Practitioner who requests an extension of any time limit or adjournment which is granted waives any right to insist on any other time limits specified herein being complied with.

5.8 GOOD FAITH – ALTERNATIVE SPECIAL NOTICE

- 5.8-1 Good Faith. In addition to those duties imposed in the Bylaws, it shall be the duty of each Staff Member or Initial Applicant who request a formal hearing to act with utmost good faith before and during the hearing process. Such good faith shall include, but not be limited to, timely compliance with requirements, cooperation in the receipt of required

notices, and the exercise of procedures in this Plan without intent to cause undue delay. In addition to other automatic hearing and appeal right waivers for non-compliance with time limits or appearance requirements, upon a finding by a hearing committee, hearing officer, or the Board that an Affected Practitioner is not acting or has not acted in good faith with regard to the hearing process of this Plan, the hearing committee, hearing officer or Board may limit or deem waived the Affected Practitioner's rights to hearing, appeal, or use of particular procedures in a hearing or appeal.

- 5.8-2 Alternative Mailing. If, in attempting to give Special Notice, postal authorities, despite reasonable efforts, are unable to deliver or obtain signature on a return receipt for registered or certified mail, or a representative of the Hospital, despite reasonable efforts, is unable to make personal delivery, at the designated place of mail delivery for the Affected Practitioner, such Special Notice may alternatively be given by regular mail that is mailed at least five days before any deadline to the last home address and last office address provided by the Affected Practitioner to Administration.
- 5.8-3 Time Limits Constructive Receipt. For the purpose of time limits of this Plan, if the mailing procedure of 5.8-2 is used, the document mailed shall be deemed to have been received at the time the first attempt at registered or certified mail by postal authorities or personal delivery by Hospital personnel was attempted, as documented by the written statement of either. This presumption of receipt shall be binding on the Affected Practitioner, even if it means rights to hearing, appeal, or objection are waived by failure to comply with time limits. This presumption may be overcome only by a clear and convincing showing to the presiding officer that the failure to make delivery or sign a receipt was due to error, neglect, or unreasonable delay of the postal authorities or Hospital representatives, and not Affected Practitioner.
- 5.8-4 Designated Place of Mail Delivery. The designated place of mail delivery shall be the office address last provided by the Affected Practitioner to Administration and any person who signs a receipt for mail there shall be deemed as authorized by the Affected Practitioner to do so. In the event of his/her absence, each Affected Practitioner shall either:
- (a) Authorize his/her office staff members to receive and sign receipts for mail on his/her behalf, or alternatively,
 - (b) If his/her office shall be closed for more than two successive business days or he/she does not wish his/her office staff to be authorized to receive and sign a receipt for mail on his/her behalf, he/she must in writing sent by certified mail to the Hospital President, designate the name and address of an alternate place of delivery (e.g., a law or accounting firm) and provide a statement that any person who receives and signs for mail there is authorized to do so on his/her behalf.
- 5.8-5 Purpose Good Faith. The purpose of the foregoing provisions of 5.8-2, 5.8-3 and 5.8-4 are to assure reasonable efforts to give required notices and proceed forward with requested hearings are not thwarted or delayed by refusal to accept delivery, refusal to sign receipts,

office closure, absence from the community, or the bad faith on the part of an Affected Practitioner.

5.9 CONSOLIDATION

If two or more hearings and/or appeals with respect to the same Staff Member are proceeding simultaneously (e.g., summary suspension and non-reappointment), the Board, at the request of the affected Staff Member, the Hospital President, PMS, or the Executive Committee, may order the two proceedings consolidated into a single hearing or appeal. In this respect, the Board shall have the authority to suspend or modify time limits and take whatever action is most reasonable and fair to all concerned to accommodate the consolidation.

ARTICLE VI

AMENDMENT AND APPLICATION

6.1 AMENDMENT

This Plan which is an appendix to the Bylaws may be amended or repealed, in whole or in part, by a resolution of the Staff recommended to and adopted by the Board subject always to the Bylaws of the respective bodies.

6.2 APPLICATION

Any matter subject to review or hearing pursuant to the Bylaws after adoption of this Plan by the Board shall be governed by its terms; prior review and hearing procedures shall be deemed superseded by the terms of this Plan.