

**MERCYONE CLINTON MEDICAL CENTER
CLINTON, IOWA
REVISED BYLAWS RULES AND REGULATIONS
OF THE MEDICAL STAFF**

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**REVISED
BYLAWS, RULES AND REGULATIONS
OF THE MEDICAL STAFF**

**MERCYONE CLINTON MEDICAL CENTER
CLINTON, IOWA**

I: PURPOSE

Mercy Medical Center-Clinton (MMC-C) dba MercyOne Clinton Medical Center is a nonprofit member of MercyOne and Trinity Health and operates as an acute care hospital. Applicable law and regulation require that the practitioners authorized to practice at the hospital be organized into a medical staff that is accountable to the hospital's governing body for the quality of medical care provided to hospital patients.

The hospital medical staff oversees, and strives to improve, the quality of patient care in the Hospital, while working cooperatively with the Chief Executive Officer or designee and the Board to fulfill the hospital's commitment to its patients. The practitioners authorized to practice in the hospital are organized into a Medical Staff in conformity with the following Bylaws that describe the structure and governance of the Medical Staff.

DEFINITIONS

**ADVANCED PRACTICE
PROFESSIONALS (APP)**

A licensed Practitioner (other than a Physician, Dentist, or Podiatrist) who has been granted clinical privileges at the hospital. The Board of Directors, after soliciting the recommendation of the Medical Executive Committee shall determine from time to time which licensed professions are eligible for APP status. APPs are not members of the Medical Staff. APPs include both individuals who are employed by the hospital and those who are not (change AHP to APP throughout the document)

**BOARD CERTIFIED OR
BOARD CERTIFICATION**

Certification as a specialist or sub-specialist by a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, or the American Dental Association's Commission on Dental Accreditation, or certification by the American Board of Podiatric Surgery.

**BOARD CERTIFIED OR
BOARD ELIGIBILITY**

A Practitioners eligibility to sit for the certification examination offered by such a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association's Commission on Dental Accreditation, or the American Board of Podiatric Surgery.

**BOARD OF
DIRECTORS**

The Governing Board of MercyOne Clinton Medical Center, Clinton, Iowa.

CLINICAL PRIVILEGES

Authorization granted by the Board of Directors to a Member, to an APP (acting under the supervision of a designated Supervising Member), or to a House Physician, or temporary authorization granted to a Practitioner in accordance with these Bylaws, to provide specific form(s) of direct patient care to patients in the hospital within well-defined limits.

CONTRACT PRACTITIONER

A medical staff member who furnishes patient care services at the hospital pursuant to the contract between the member and the hospital or on behalf of an entity that contracts with the hospital.

DENTIST

A licensed dentist holding unlimited licenses in the State of Iowa who is privileged to attend patients at this hospital.

**MEDICAL EXECUTIVE
COMMITTEE**

The Medical Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Board.

**FOCUSED PROFESSIONAL
PRACTICE EVALUATION OR
FPPE**

The time-limited evaluation of a member of the medical staff's competence in performing specific clinical privileges and professional behavior.

HOSPITAL

MercyOne Hospital and all locations billed as inpatient or outpatient departments of MercyOne Hospital.

MEDICAL STAFF

All medical and osteopathic physicians and surgeons holding unlimited licenses in the State of Iowa and duly licensed dentists and podiatrists in the State of Iowa who are privileged to attend patients at this hospital.

MEDICAL STAFF POLICY

A policy adopted by the Medical Executive Committee that implements the standards stated in these Bylaws or establishes procedures to accomplish the processes described in these Bylaws and that is consistent with these Bylaws and approved by the Board of Directors

ONGOING PROFESSIONAL PRACTICE EVALUATION OR OPPE

Ongoing collection, verification and evaluation of data relevant of a member of the medical staff or AHP's clinical competence and professional behavior.

PATIENT CONTACT

Being listed as the admitting physician, physician, oral-maxillofacial surgeon or consultant on an in-patient admitting form.

OR

Although not listed as the admitting physician, oral-maxillofacial surgeon or physician, nevertheless serving as the de facto physician in charge of the medical management of a patient during said patient's period of hospitalization; and

OR

Performing any service listed as a clinical evaluation, surgical operation, diagnostic procedure or non-surgical procedure in the Current Procedural Terminology (CPT) or International Classification for Diseases (or the most currently acceptable classifications) or administering any type of anesthesia for such procedures whether the patient be classified as an inpatient or an outpatient.

PHYSICIAN

All medical and osteopathic physicians holding unlimited licenses in the State of Iowa who duly meet all requirements for Medical Staff Membership in accordance

with these Bylaws.

PODIATRIST

A licensed podiatrist holding unlimited licenses in the State of Iowa who is privileged to attend patients at this hospital.

PRACTITIONER

An appropriately licensed medical physician, an osteopathic physician, or surgeons with an unlimited license or an appropriately licensed dentist or podiatrist.

PRESIDENT

The highest ranking position in the hospital.

**RULES &
REGULATIONS**

The Rules and Regulations of the Medical Staff and of the Medical Staff departments, adopted in accordance with these Bylaws.

SUPERVISING MEMBER

A Physician Member of the Medical Staff who is approved pursuant to these Bylaws to supervise the exercise of Clinical Privileges by an Advanced Practice Professional

**TELEMEDICINE CLINICAL
PRIVILEGES**

Clinical Privileges that authorize provision of clinical services to Hospital patients from a distance via electronic communications

TELEMEDICINE PROVIDER

A Medicare-participating hospital or other telemedicine entity that pursuant to a written agreement with the Hospital which satisfies the requirements of the Medicare Hospital Conditions of Participation, furnishes the Hospital the services of qualified Practitioner(s) who are granted Telemedicine Clinical Services of the Hospital

TIME COMMITMENTS

In these Bylaws, those time commitments are commitments that the Medical Staff, Governing Board, and the Hospital Administration have a good faith obligation to meet but can be waived as the Medical Staff, Governing Board, and Hospital Administration deem appropriate.

II: NAME

The name of this organization shall be the Medical Staff of
MercyOne Clinton Medical Center.

III: MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership of the Medical Staff and Clinical Privileges (including temporary Clinical Privileges) are privileges, not rights, that extended only to Practitioners who the hospital determines continuously meet the qualifications and satisfy the requirements stated in these Bylaws. Decisions on membership and Clinical Privileges are made by the Board, in its discretion, acting on the recommendation of the Medical Executive Committee. No Practitioner shall be entitled to Medical Staff Membership or Clinical Privileges merely by virtue of licensure to practice a profession, Board Certification or Eligibility, membership in any professional organization, clinical privileges at another health facility, prior membership or Clinical Privileges at the Hospital, or Contract. Decisions regarding Medical Staff membership and Clinical Privileges will not be based on race, color, sex, national origin, religion, age, and any other criterion prohibited by law. A Member may furnish patient care at the Hospital only within the limits of Clinical Privileges granted in accordance with these Bylaws.

Section 2. Qualifications for Membership

- a. Only practitioners licensed to practice in the State of Iowa who can document their background, experience, training and demonstrated competence, their health status, their adherence to the ethics of their profession, their good reputation, with sufficient adequacy to assure the Medical Staff and the Governing Board that any patient treated by the practitioner in the Hospital will be given a high quality of medical care, shall be qualified for membership on the Medical Staff. No practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice medicine or dentistry or podiatry in this or any other state, or that he/she is a member of any professional organization or that he/she had in the past, or presently has, such privileges at another Hospital.

The applicant must be practicing in the community or within a reasonable distance of the Hospital. Tele-providers may be exempt from residence status provided they have the capability of interpreting radiologic services offsite, but will be personally available if necessary.

- b. Acceptance of membership on the medical staff shall constitute the Staff Member's agreement that he/she will abide by the Bylaws, Rules and Regulations of the Medical Staff and the Governing board, the Ethical and Religious Directives for Catholic Health Care Services, and by the principles of the Medical Ethics of the American Medical Association or the Code of the American Dental Association, whichever is applicable.
- c. All members shall meet the malpractice requirements as annually established by the Mercy Medical Center - Clinton Board of Directors. Any disagreements as to the

required amount shall be referred to the Executive Committee.

- d. A practitioner's application for Medical Staff Membership will be returned unprocessed if the practitioner fails to satisfy any of the following basic qualifications for membership:
- Holds an unrestricted license to practice his or her profession in the State of Iowa
 - Holds an unrestricted DEA registration and a Iowa Controlled Substance license, if the applicant seeks Clinical Privileges to prescribe controlled substances or if such registration or license is required by the department to which the applicant likely will be assigned
 - Maintains professional liability insurance set at the state requirements or as otherwise directed by Trinity Risk
 - If the applicant is a Physician or Podiatrist has completed a residency that satisfies Hospital requirements
 - Is not involuntarily excluded from any federal health care program, such as Medicare or Medicaid
 - Is Board Certified/Board Eligible in the specialty and subspecialty in which Clinical Privileges are requested, or the applicant will certify within the allowed time of their specialty and subspecialty

Section 3. Conditions and Duration of Appointment

- a. Initial appointments and reappointments to the medical Staff and the delineation of clinical privileges shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, or revocation of appointments and the delineation of privileges after there has been a recommendation from the Medical Staff as provided in these Bylaws.
- b. Initial appointments shall be for a period of up to twelve (12) months.
- Reappointments shall be for a period of not more than two (2) Medical Staff years. For the purposes of these Bylaws, the Medical staff year commences on the second Tuesday of July and ends on the day preceding the second Tuesday of July of each year.
- c. Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Board, in accordance with these Bylaws. The clinical privileges granted may be practiced in all applicable areas of MercyOne Clinton Medical Center, i.e., acute care, home care, and long term care.
- d. Every application for Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his/her patients, to abide by the Medical Staff Bylaws, Rules and Regulations, to accept committee assignments and to attend all departmental and committee meetings as required by the Bylaws and Rules

and Regulations of the Medical Staff.

- e. A Contract Practitioner's Clinical Privileges to perform those patient care services covered by the contract with the Hospital shall terminate automatically without Due Process, upon termination of the contract with the Hospital or upon termination of the Practitioner's association with the entity that contracts with the Hospital; if all of a Contract Practitioner's Clinical Privileges are terminated in this manner, the Contract Practitioner's Medical Staff membership shall also terminate automatically.

Section 4. Other Criteria for Medical Staff

In addition to the basic qualifications, the following criteria are evaluated in acting upon with application for the Medical Staff. The applicant's education, training, experience, judgement, health status, character, and demonstrated competence are sufficient to enable the applicant to provide high quality, efficient, and ethical medical care and to exercise capably Clinical Privileges requested. The evidence relevant to these criteria includes:

- a. Challenges to any licensure or registration
- b. Voluntary and involuntary relinquishment of an license or registration
- c. Voluntary and involuntary termination of medical staff membership at any facility
- d. Voluntary and involuntary limitation, reduction, or loss of clinical privileges at any facility
- e. Professional liability actions either pending or resulting in a final judgment or settlement payment with respect to the applicant
- f. Peer and/or faculty references
- g. Relevant Practitioner-specific data as compared to aggregate data, when available
- h. Morbidity and mortality data when available
- i. The applicant is able and willing to work harmoniously with other healthcare professionals and Hospital personnel and maintain a good relationship with patients
- j. The applicant adheres to the ethics of his or her profession
- k. The applicant provides evidence of arrangements with another Member who holds appropriate Clinical Privileges and who will provide coverage for the applicant's patients when the applicant is unavailable

Section 5. Responsibilities of Medical Staff Membership

Each member shall continuously fulfill these responsibilities:

- a. Provide patients with care in the Hospital at the generally recognized level of quality and efficiency, including arranging consultations when appropriate, providing daily care and supervision for Hospital inpatients who are under his or her care, and providing coverage at all times for his or her patients who are in the Hospital or who present at the Hospital (either personally or through arrangements with another qualified member)

- b. Abide by these Bylaws, the Rules (Code of Conduct, etc.), Trinity Health's Corporate Compliance Plan, and the ethical code of the Member's profession
- c. Comply with the Ethical and Religious Directives of Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops
- d. Participate in Staff activities, at a level consistent with his Staff category, and carry out all duties for which the Member is responsible by appointment, election, or otherwise
- e. Treat employees, patients, volunteers, visitors, and other Practitioners at the Hospital in a dignified and courteous manner
- f. Timely complete medical records within the scope of his or her Clinical Privileges at the request of the Member treating the patient
- g. Perform timely inpatient consultation within the scope of his Clinical Privileges at the request of the Member treating the patient
- h. Comply with applicable state and federal laws and regulations
- i. Be available to furnish emergency care at the Hospital in accordance with the Rules

Report any of the following events in writing to the Chief of Staff

- a. The Member is convicted of (or pleads guilty or no contest) a felony
- b. Disciplinary action imposed on the Member by a licensed health facility
- c. The Member resigns or limits his clinical privileges at a licensed health facility while under investigation or in order to avoid an investigation or proceedings
- d. The Member's license to practice a health profession or to prescribe drugs in any jurisdiction is terminated, limited, placed on probation, relinquished, or lapses,
- e. Payment is made in settlement or judgement of a professional liability claim against the Member

Comply with the following requirements with respects to Member's patients

- a. A physical examination and medical history must be completed within 24 hours after a patient is admitted or registered and in any event before the patient undergoes surgery or a procedure requiring anesthesia
- b. A history and physical performed more than 30 days before the patient was admitted or registered may be used, provided an updated examination of the patient is completed and documented no later than 24 hours after the admission or registration, and in any event before the patient undergoes surgery or a procedure that requires anesthesia.
- c. A history and physical exam required must be performed by an individual who holds Clinical Privileges to perform history and physicals
- d. Once Board Certified, all Physician, Podiatrists, and Oral Surgeon Members must maintain Board Certification in the specialty or subspecialty or which they hold Clinical Privileges. Compliance with this requirement is assessed at the time of reappointment

IV: CATEGORIES OF MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into Active, Limited Active, Consulting, and Emeritus Categories. A practitioner may request a change in categories at any time between two-year appointments. All medical staff members, with the exception of Emeritus Medical Staff, must perform three acute care admissions, consultations or procedures within each appointment cycle. Consultation shall be defined as direct patient care activity within the hospital system and includes directing hospital radiology, pathology or laboratory services. All members of the Active and Limited Active Categories of the Medical Staff, with the exception of emergency room physicians who have their own coverage arrangements, must have appropriate call coverage by an Active Medical Staff member. Any Medical Staff member naming an alternate for call coverage must first procure the written consent of the Medical Staff member being named. Call coverage arrangements will be approved through the normal credentialing process.

Section 2. The Active Medical Staff

The Active Medical Staff shall consist of practitioners who admit/consult ten (10) or more patients within the acute care facility annually, and who assume all functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency service care and consultation assignments. Members of the Active Medical Staff must reside within a 50-mile radius of the hospital and, when on call, be able to respond within 30 minutes or less for an emergency medical condition. Practitioners who are under exclusive contract and provide point of service care may be exempt from residency status if adequate call coverage and continued care is provided. Radiologists may be exempt from residence status provided they have the capability of interpreting radiologic services offsite, but will be personally available if necessary. Members of the Active Medical Staff shall be appointed to a specific Department (and, unless excused by the Department, shall participate in an on-call schedule for that Department, if established), shall be eligible to vote, to hold office and to serve on medical staff Committees, and shall be required to attend Medical Staff meetings.

Emergency Room practitioners are limited to providing care in the emergency room and cannot provide consultation services or admit patients other than responding to acute emergencies for inpatients as set forth in Article VI: Clinical Privileges, Section 3. Emergency Privileges.

Section 3. The Limited Active Medical Staff

The Limited Active Medical Staff shall consist of practitioners qualified for staff membership but who are limited to twenty (20) patients per two-year term but not to exceed fifteen (15) in any one year, regardless of the number of changes in status during the two-year term. If the practitioner wishes to exceed the maximum, he/she must apply for and be approved for Active Medical Staff privileges by completion of the Clinical Privileges Delineation form and comply with the requirements of that category. Members of the Limited Active Medical staff may attend General Medical Staff meetings as scheduled quarterly and will be assigned to a department but will not be required to attend department meetings. Limited Active Medical Staff will not be

assigned to medical staff committees. They cannot hold office or vote at General Medical Staff meetings. Limited Active Medical Staff members are not required to reside within the hospital service area. This category includes part-time physicians.

Section 4. The Consulting Medical Staff

The Consulting Medical Staff shall consist of four types of practitioners who are otherwise qualified for staff membership:

- a. Practitioners who act only as consultants and who do not admit patients. This category is exempt from minimum patient care activity requirements; or,
- b. Practitioners in the general referral area of the hospital who are acting as surgical assistants only for their patients; or,
- c. Practitioners who are (full-time) members of the faculty at the University of Iowa College of Medicine (holding the rank of Professor, Associate Professor or Assistant Professor) or residents in a program at the College of Medicine and who do not live in the community but who are providing medical services within the community as part of an accredited education program of the University of Iowa College of Medicine; or,
- d. Practitioners who are under contract with the hospital to perform services for which no local practitioner is qualified or reasonably willing to perform.

Consulting Medical Staff shall be appointed to a specific department but shall not be eligible to vote or hold office in such medical staff department. Consulting Medical Staff may serve on medical staff committees at the discretion of the medical staff and as a member of such committees but are ineligible to vote at those committee meetings. Consulting Medical Staff members may attend General Medical Staff meetings but are ineligible to vote.

Section 5. The Emeritus Medical Staff

The Emeritus Medical Staff shall consist of practitioners not active in the hospital and who are honored by emeritus positions. They may be practitioners who have retired from active hospital service or practitioners of outstanding reputation who are not necessarily residents in the community. Emeritus Medical Staff members are not eligible to admit or attend patients and may not vote or hold office, but may attend medical staff meetings.

Section 6. Appointments Provisional

- a. All initial appointments to any category of the Medical Staff will be under the Focused Professional Practice Evaluation (FPPE) according to the Medical Staff Policy for OPPE/FPPE. FPPE may occur in requests for new privileges. In order to advance from Provisional Staff to Regular Staff, two acute care admissions, consultations or

procedures must be performed within the one year period of provisional membership, with the exception of Consulting Medical Staff who do not admit patients (Section 4A). Reappointments to provisional membership may not exceed one full medical staff year, at which time, failure to advance an appointee from Provisional Staff to Regular Staff status shall be deemed a termination of Regular Staff appointment unless such failure to advance an appointee is due to a failure of the appropriate department, Credentials Committee, Executive Committee, or the General staff (other than an adverse recommendation) to act on the advancement. A provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a member of the Medical Staff who has failed to be reappointed.

- b. Staff members should be assigned to a department and their performance should be evaluated by the Medical Staff Committees provided for in these Bylaws. It shall be the right of any Committee, Department Chair, or Officer of the Medical Staff to devote special observation to the clinical work and the records of the clinical work of any provisional staff member as is seen fit. This is to be interpreted as proper supervision and is not to be interpreted as discrimination.
- c. Because of the frequency of a particular procedure, it is the prerogative of the Department or General Staff to require competent performance of a particular procedure or a number of procedures or the management of a problem or problems to be reviewed before a certain category of Staff membership or privileges are allowed. The time involved may exceed the previously mentioned twelve (12) months. If so, the conditions listed in this present paragraph take precedence over the time mentioned in subparagraph a, Section 6 of this Article.
- d. All Medical Staff members, with the exception of Consulting Medical Staff who do not admit patients (Section 4A), must admit and/or consult a minimum of three (3) patients during the two year period between reappointments in order for the physician's quality and appropriateness of patient care to be evaluated at the time of reappointment. A letter will be sent to a physician three (3) months prior to his/her reappointment date if he/she has not met the criteria in order for him/her to be able to present before the medical staff to supply documentation of patient care. If a physician does not meet the requirement of seeing at least three (3) patients within a two-year period between his/her reappointment, he/she will have to go through the initial appointment process again, but will not have to resubmit documents such as medical school diploma, residency verification, copy of state medical license, etc.

He/she will have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

In the case of surgical assistants from the general area who may neither admit or consult on three patients during the above period of time, evaluations from the primary surgeon involved that they have assisted may serve as evidence of the quality and performance of his/her abilities. The application shall include the names of at least two (2) persons

who have had extensive experience in observing and working with the applicant's professional competence and ethical character and shall include information as to whether the applicant's membership status and/or clinical privileges have been revoked, suspended, or reduced or not renewed at any other Hospital or institution, and as to whether membership in local, state or national medical societies or license to practice any profession in any jurisdiction has been suspended or terminated in the last two (2) years since his/her last appointment or reappointment process. The application shall also require information as to whether the applicant's narcotic license has been suspended or revoked. The application shall also include the applicant's statement of his/her health status.

The process of his/her application will then follow the prescribed process of appointment starting with Article V, Section 3 of the Revised Bylaws, Rules and Regulations of the Medical Staff.

Section 7. Leave of Absence

- a. **Leave Status** – At the discretion of the Executive Committee of the Medical Staff, a medical staff member may obtain a voluntary leave of absence from the staff by submitting a written request to the Executive Committee stating the approximate period of leave desired, which may not exceed two years. During the period of leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive.
- b. **Termination of Leave** – At least 90 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the Executive Committee. The staff member shall submit a summary of relevant activities during the leave, if the Executive Committee so requests. The Executive Committee shall make a recommendation concerning reinstatement of the member's privileges, and the procedures set forth in Section 4 (Reappointment Process) shall generally be followed, as applicable.
- c. **Failure to Request Reinstatement** – Failure, without good cause, to make a timely request for reinstatement shall be deemed a voluntary resignation from the medical staff and shall result automatic termination of membership and privileges. A member whose membership is thus terminated shall be entitled to procedural rights provided in Article IX (Hearing and Appellate Review) for the sole purpose of determining whether there was good cause for the failure to request reinstatement. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for application for initial appointments.
- d. **Short-Term Leaves** – For Leaves of Absence three (3) months or less, as in the stance of maternity or short-term medical leave, request for Leave and reinstatement may be handled at the department level in lieu of utilizing the formal Leave of

Absence process. However, the provider and/or department must assure that there is appropriate patient care coverage during such absence. Further, reinstatement is contingent upon health status and clinical ability pursuant to specified clinical privileges.

Section 8. Community Staff

- a. **Qualifications** - The Community Staff category consists of those Members who meet the standards set forth in the Mercy Medical Center Medical Staff Bylaws who do not hold Clinical Privileges at the Hospital, but who arrange for their patients to be admitted to the Hospital under the care of another Member.
- b. **Prerogatives – A Member of the Community Staff:**
 - 1. **Clinical Privileges** - Is not eligible for any Clinical Privileges, including admitting Clinical Privileges, but may only review the Hospital clinical charts of their patients for treatment purposes.
 - 2. **Meetings/Voting** - May attend Medical Staff, department and committee meetings, but may not vote.
 - 3. **Office** - May not hold Medical Staff, department, or committee office.
 - 4. **Hospital Facilities** - May use the Hospital medical library and dining rooms and attend CME programs at the Hospital.
 - 5. **Responsibilities** - None, except to comply with any policy applicable to their use of Hospital facilities.

V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Pre-Application for Appointment

- a. All physicians, dentists or podiatrists interested in applying for appointment to the Medical Staff shall make pre-application. This pre-application shall be used in determining eligibility to apply for Medical Staff membership and/or privileges. Pre-applications shall be in writing and shall be signed by the applicant. Pre-application materials shall be reviewed by the Medical Staff Coordinator.
- b. All physicians, dentists, or podiatrists who meet pre-requisites as described above shall have their application processed by the Medical Staff.

Section 2. Application for Appointment

- a. All applications for appointment to the medical staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board after consultation with the General Medical Staff. The application shall require detailed information concerning the applicant's professional qualifications, shall include the name of at least three people who have had extensive experience in observing and working with the applicant's professional competence and ethical character and shall include information as to whether the applicant's membership status and/or clinical privileges have ever been or are currently pending being revoked, suspended, reduced or not renewed at any other Hospital or institutions, and as to whether membership in local, state or national medical societies, or license to practice any profession in any jurisdiction has ever been or is currently pending being suspended or terminated. The application may also request information as to whether the applicant's narcotic license has ever been or is currently pending being suspended or revoked.
- b. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.
- c. In addition to the application form, copies of the following should be included: a copy of the physician's medical school diploma; a copy of the physician's residency certification or letter of satisfactory completion from an accredited residency program or documentation of Board Certification by a Board recognized by the American Board of Medical Specialties. If a physician is still in residency, a letter from the Residency Department declaring the appropriateness of the physician to function in the position he/she has applied for. Variance is subject to the discretion of the Executive Committee; a copy of his/her Iowa State License to practice medicine; copies or the originals of three letters of recommendation from physicians who were associated with him/her in his/her last significant place of endeavor (if a person has completed a residency, one of these letters should be from the head of the department in which the residency was taken); any additional letters of reference or other information thought necessary by the

Credentials Committee; and a letter of reference from the Administrator from the last Hospital in which he/she worked, and a certified malpractice certificate. At its discretion, the Credentials Committee may require that any of the foregoing documents be notarized.

- d. The completed application shall be submitted to requested Department Chair. The Department Chair shall review the application in writing when the application is deemed complete. All department chairs in which an applicant seeks privileges shall receive a copy of the completed application for evaluation and signature.
- e. By applying for appointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the Hospital to consult with members of medical staffs of other Hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications, consents to the Hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges he/she requests as well as of his/her moral and ethical qualifications for staff membership, releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

The terms "Hospital" and "all representatives of the Hospital and its Medical Staff" as used in this section are intended to include the Governing Board and the Chief Executive Officer and their authorized representatives, and all members of the Medical Staff who have committee or other responsibility for collecting and/or evaluating the applicant's credentials and/or acting upon his/her application. The term "character" is intended to include mental and emotional stability.

The application form should include a statement that fully informs the applicant of the scope and extent of these authorizations, release and consent provisions, and the immunity provisions contained in Article XIV of these Bylaws.

- f. The application form should include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff and that the Bylaws, Rules and Regulations of the Medical Staff have been fully described to the applicant and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application. The application form shall also include a statement that the applicant pledges to provide for continuous care for his/her patients and acknowledges any provisions in the Medical Staff Bylaws for release and immunity from civil liability, in the event Medical Staff privileges are not granted to the applicant.

g. **Privilege Modification**

Request for Additional Privileges: A member of the Medical Staff may request an increase in Clinical Privileges any time during the term of his/her appointment by submitting a written request in accordance with the Medical Staff Bylaws. Any such request will be processed using the same procedure as for a request for appointment or reappointment.

Voluntary Withdrawal of Privileges: A member of the Medical Staff may request a voluntary withdrawal in Clinical Privileges any time during the term of his/her appointment by written request to the Credentials Committee. Any such request will be processed using the same procedures as for a request for appointment or reappointment.

Section 3. Appointment Process

- a. The Department Chair and Credentials Committee will review each application and its associated information, and will categorize the application pathway according to the following criteria:

Pathway One

1. All requested information has been returned promptly.
2. There are no negative or questionable recommendations.
3. There are no discrepancies in information received from the applicant or references.
4. The applicant completed a normal education/training sequence.
5. There have been no disciplinary actions or legal sanctions.
6. There have been less than 3 malpractice judgments within the past three years.
7. The applicant has an unremarkable medical staff/employment history.
8. The applicant has submitted a reasonable request for clinical privileges based on experience, training, and competence and is in compliance with applicable criteria.
9. The applicant reports an acceptable health status.
10. The applicant has never been sanctioned by a third-party payer (e.g., Medicare, Medicaid, etc.), or been an excluded provider.
11. The applicant has never been convicted of a felony.
12. The applicant is requesting privileges consistent with his or her specialty.

Pathway Two

1. Peer references and/or prior affiliations indicate potential problems (e.g., difficulty with interpersonal relationships, minor patient care issues, etc.).

2. There are discrepancies between information the applicant submitted and information received from other sources.
 3. Privileges the applicant requested vary from those requested by other practitioners in the same specialty.
 4. There are gaps in time for which the applicant has not accounted.
 5. There are unsatisfactory peer references and/or prior affiliation references.
 6. Disciplinary actions have been taken by a state licensing board or a state or federal regulatory agency, or there has been a felony conviction.
 7. The applicant has experienced involuntary termination of medical staff membership, or involuntary limitation, reduction, or loss of clinical privileges at another health care organization.
 8. The applicant has experienced removal from a provider panel of a managed care entity for reasons of unprofessional conduct or quality-of-care issues.
 9. The applicant has been the object of three or more malpractice settlements/judgments in the past three years.
 10. The applicant has held five new licenses in the past five years across the United States (exception may include telemedicine or locum tenens physicians).
 11. The applicant has had many health care organization affiliations in multiple areas during the past five years (exception may include telemedicine or locum tenens physicians).
 12. Failure to complete medical records (reference: Medical Staff Suspension Policy)
- b. If the applicant is placed in Pathway One, the following steps occur:
1. The medical staff office receives and processes the application.
 2. The appropriate Department Chair reviews the completed and verified application.
 3. The Credentials Committee reviews and makes a recommendation to the Medical Executive Committee (MEC).
 4. The MEC will review and make a recommendation for expedited approval by Board delegates.
- c. If the Department Chair, Credentials Committee, or MEC's recommendation is negative or differs from the original classification, the application is automatically classified as Pathway Two and processed accordingly:
1. The Credentials Committee may meet with the applicant to discuss any aspect of the application, the applicant's qualifications and clinical privileges requested before making a recommendation to the Executive Committee. If the Credentials Committee meets with the applicant, a report of that meeting will be in writing, signed and dated.
 2. The Credentials Committee then forwards the application to the MEC for review and recommendation. The chairperson of the Credentials Committee,

or another designated member of the committee, should be available to the Medical Executive Committee to answer any questions that may be raised with respect to the committee's recommendation.

3. The MEC forwards the application with its recommendations to the Executive Committee of the Governing Board for final action.
- d. When the recommendation of the Executive Committee is adverse to the practitioner in respect to appointment or clinical privileges, the recommendation, if the affected practitioner so desires, shall be forwarded to the President of the Medical Staff who shall present the recommendation at the next General Medical Staff meeting, or if no General Medical Staff Meeting is scheduled to occur within 60 days from the President's receipt of the recommendation, then at a Special General Medical Staff meeting called for the purpose of reviewing the Executive Committee's recommendation. The General Medical Staff, based upon its evaluation of the Executive Committee recommendation, the Credentials Committee recommendation, and the chair, vice chair or designee of the Staff Department(s) recommendation, shall submit a written report to the Chief Executive Officer, including its recommendations that the practitioner be provisionally appointed to the Medical Staff, that he/she be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted which may where appropriate be qualified by probationary conditions.
 - e. When the recommendation of the General Medical Staff is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection for Staff Membership.
 - f. When the recommendation of the General Medical Staff is favorable to the practitioner, the Chief Executive Officer shall forward it, together with all supporting documentation to the Governing Board at the Board's next regularly scheduled meeting.
 - g. When the recommendation of the General Medical Staff is adverse to the practitioner, either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by Certified Mail. A notice of this recommendation should be forwarded to the Governing Board also. Such notification should include a notice to the applicant of his/her right to a hearing as provided in Article IX of these Bylaws.
 - h. If after the General Medical Staff has considered the report and recommendation of the Hearing Committee and the hearing record, the General Medical Staff's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph h. of this Section 3. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner by Certified Mail and such notification should also advise the applicant of his/her right to appeal according to Article IX of these Bylaws. The Chief Executive Officer shall also forward such recommendation and documentation to the Governing Board but the governing board

shall not take any action thereon until after the practitioner has exercised or has deemed to have waived his/her right to an appellate review as provided in Article IX of these Bylaws.

- i. At its regular meeting after receipt of favorable recommendation, the Governing Board or its executive committee shall act in the matter. If the Governing Board's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him/her of such adverse decision by Certified Mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under Article IX of these Bylaws and until there has been compliance with subparagraph l. of this Section 3. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- j. At its next regular meeting after all of the practitioner's rights under Article IX have been exhausted or waived, the Governing Board or its duly authorized Committee shall act in the matter.

The Governing Board's decision shall be conclusive, except that the Governing Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in a matter, if any, the governing Board shall make a decision either to provisionally appoint the practitioner to the Staff or to reject him/her for Staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

- k. When the Governing Board's decision is final, it shall send notice of such decision through the Chief Executive Officer to the President of the Medical Staff, to the Chairman of the Executive Committee and to the Department Chairman concerned, and by Certified Mail, return receipt requested, to the practitioner.
- l. All new privileges granted to a practitioner will undergo a FPPE in accordance with the Medical Staff Policy on Focused Professional Practice Evaluation Policy and Procedure.

Section 4. Reappointment Process

- a. The Department Chair and Credentials Committee will review each application and its associated information, and will categorize the application according to the criteria established and process for appointment per Section 3 of this Article V.

The Credentials Committee shall make recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period of reappointment which shall not exceed two Medical Staff years. At least 90 calendar

days prior to the Medical Staff member's birth month in the calendar year he/she is up for review, the chair, vice chair or designee of the Department in which he/she has privileges shall review all pertinent information described in Section 4 d. below concerning the practitioner scheduled for periodic appraisal, and shall transmit his/her recommendations, in writing, to the Credentials Committee after receipt of the completed application for reappointment to the Medical Staff. The Credentials Committee shall recommend for each staff member reviewed that he/she (1) be reappointed without changing clinical privileges, (2) be reappointed with different clinical privileges, or (3) not be reappointed. Where non-reappointment or change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

A Practitioner who fails to file a timely application for reappointment to the Medical Staff or renewal of Clinical Privileges shall automatically cease to be a Medical Staff Member and cease to hold Clinical Privileges upon expiration of the Practitioner's term of appointment.

- b. The Credentials Committee shall provide the Medical Staff members up for reappointment with a description of the mechanism for reappointment to the Medical Staff and/or reappraisal and/or review of clinical privileges described in these Bylaws. The Medical Staff members shall provide the Credentials Committee with a statement that the reappointment process has been described to him/her and that he/she agrees to be bound in the terms thereof if he/she is granted reappointment and be bound by the terms thereof without regard whether or not he/she is reappointed.
- c. Thereafter, the procedures provided in Section 3f. through 3q. of this Article V, relating to recommendations on applications for initial appointment shall be followed in connection with the Executive Committee's, General Medical Staff's and Governing Board's recommendations specified in Section 4 a. of this Article.
- d. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon evidence of such member's current licensure, health status, professional performance, judgment and clinical/technical skills, as indicated by the results of quality improvement activities, pending and/or settled malpractice actions officially filed in court since the last reappointment, and other reasonable indications of continuing qualifications. There should also be evidence of participation in continuing education activities for the previous two years. Continuing medical education shall be not less than that required for licensure by the State of Iowa. Peer recommendations shall be a part of the basis for the development of recommendations for continued membership on the Medical Staff and for the delineation of individual clinical privileges. Recommendations from the Department Chair, Vice Chair or designee, and/or major clinical service recommendations shall be a part of the basis for the development of recommendations for continued membership on the Medical Staff and/or for the delineation of individual clinical privileges.

- e. The applicant for reappointment and/or renewal of clinical privileges shall be required to submit any reasonable evidence of current health status that may be requested by the Executive Committee of the Medical Staff.
- f. When a current member of the medical staff is requesting additional privileges or reactivation of privileges that do not meet the minimal activity requirements for Ongoing Professional Practice Evaluation (OPPE) review, the practitioner will undergo FPPE in accordance with the Medical Staff Policy on Focused Professional Practice Evaluation Policy and Procedure.

Section 5. OPPE/FPPE

FPPE

Clinical Privileges granted to initial applicants and additional Clinical Privileges granted in connection with reappointment or mid-appointment request for additional Clinical Privileges shall be subject to Focused Professional Practice Evaluation as provided in the Medical Staff Policy.

OPPE

In order to maintain Clinical Privileges, there will be an on-going collection, verification, and evaluation of data relevant to a Member's or APP's clinical competence and professional behavior

VI: CLINICAL PRIVILEGES

Section 1. Clinical Privileges Restricted

- a. Every practitioner practicing at this Hospital by virtue of Medical Staff Membership or otherwise, shall in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board, except as provided in Sections 2 and 3 of this Article VI.
- b. Every initial Application for Staff Appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Staff Department in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests. Clinical privileges which are granted to Medical Staff members, shall be related to an individual's documented experience and categories of treatment areas or procedures; the results of such treatment; and conclusions drawn from quality improvement activities as determined by the Quality Improvement Committee and the Department Chairman.
- c. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other Hospitals and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.
- d. Applications for additional clinical privileges must be in writing. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privileges desired and the applicant's relevant recent training and/or experience must be stated. Such applications should be processed in the same manner as applications for initial appointment.
- e. Privileges granted to dentists shall be based on their training, experience, and demonstrate competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during Hospitalization.

Section 2. Temporary Privileges

- a. Temporary Privileges may be granted only in the circumstances described below and only to an appropriately qualified practitioner, based on the following:
1. A complete Medical Staff application and request for clinical privileges must be submitted.
 2. The Iowa professional license must be current and verified; copies of the current Iowa controlled substance license and Federal DEA registration certificate, if applicable, must also be on file.
 3. Malpractice insurance at the state requirements.
 4. Two peer references must be on file.
 5. The AMA and NPDB must be queried and a response received. The ECFMG must be queried when appropriate, but temporary privileges will not be delayed if verified by the AMA.
 6. No current or previously successful challenge to licensure or registration.
 7. No subjection to involuntary termination of medical staff membership at another organization.
 8. No subjection to involuntary limitation, reduction, denial or loss of clinical privileges.
- b. Temporary clinical privileges may be granted by the Chief Executive Officer or his designee to provide care for patients of an absent Medical Staff member:
1. to provide a medical service not readily available from the current Medical Staff to fulfill an important patient care, treatment, and service need;
 2. to allow a physician to practice during the credentialing process after approval of the medical staff and pending Board approval.

To allow the use of **Locum Tenens** where necessary or for the care of a specific patient to a practitioner who is not an applicant for membership in the same manner and upon the same conditions set forth in subparagraph a. of this Section 2, provided that there shall first be obtained such practitioner's signed acknowledgment that he/she has received and read copies of the Medical Staff Bylaws, Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges.

- c. Upon receipt of an application for Medical Staff Membership from an appropriately licensed practitioner, the Chief Executive Officer or his designee may, upon the basis of information available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the Chair, Vice Chair or designee of the Department concerned Chair of the Credentials Committee or designee, and of the President or President-Elect or Secretary/Treasurer of the Medical

Staff, grant temporary admitting and clinical privileges to the applicant for a period not to exceed ninety (90) days, which may be extended for an additional thirty (30) day period, not to exceed one hundred twenty (120) days. In exercising such privileges, the applicant shall act under the supervision of the Department chairman of the Department to which he/she is assigned.

- d. Special requirements of supervision and reporting may be imposed by the Department Chairman concerned on any practitioner granted temporary privileges. Temporary privileges shall be a immediately terminated by the Chief Executive Officer or his designee upon notice of any failure by the practitioner to comply with such special a conditions.
- e. The Chief Executive Officer or his designee may at any time, upon the recommendations of the President of the Medical Staff or the Department Chairman concerned, terminate a practitioner's temporary privileges effective as of discharge of the practitioner's patient(s) then under his/her care 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 2. a. of Article VIII of these Bylaws, and the same shall be immediately effective. The Department Chairman or, in his/her absence, the Chairman 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 such substitute practitioner.

Section 3. Disaster Privileges

- a. In the event of a disaster as defined in the Disaster Policy, physicians not presently holding Medical Staff membership and privileges, but who are well known throughout the local medical community, will be allowed to assist in the **emergency care** of patients with the approval of the President of the Medical Staff or designees, or the appropriate Department Chair. If the disaster is of the magnitude to require medical help from outside the local community, the President of the Medical Staff or designee, or appropriate Department Chair will be given the authority to grant disaster privileges based on presentation of any of the following:
 - 1. Two forms of Photo ID,
 - 2. A current license to practice and a valid picture ID issued by a State, Federal, or regulatory agency,
 - 3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT),
 - 4. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a Federal, State, or municipal entity),
 - 5. Presentation by current hospital or medical staff member with personal knowledge regarding the practitioner's identity.

- b. Any physician granted disaster privileges will be retrospectively credentialed as follows:

The Medical Staff office will:

1. Call the hospital at which the physician has his/her main affiliation and verify that the physician is in good standing at that facility.
2. Call the appropriate State licensing board to verify the standing of the license and to inquire if there have been or are any pending disciplinary actions.

In the case of a physician coming from outside of the area and not known locally, permission to begin work will be delayed (if at all possible given the circumstances) until the above verifications have been made. Once granted Disaster Privileges, the practitioner shall be assigned to a department of the medical staff, and to a member of the medical staff with similar privileges to whom the practitioner shall report for assignment for the treatment of patients and who shall supervise the practitioner during the emergency appointment period. Emergency privileges shall be specialty-specific (within the practitioner's scope of practice).

- c. In all instances, emergency privileges would expire after forty-eight hours unless the emergency persists and both the President of the Medical Staff or designee and the Chief Executive Officer or designee are in agreement to extend disaster privileges.
- d. Practitioners granted disaster privileges will be issued an ID badge with red lettering to readily identify these individuals.

VII: IMPAIRED PRACTITIONER

Section 1. Purpose

- a. Whenever it is believed that a practitioner may have a chemical dependence, mental or physical illness, or other condition which may affect a practitioner's ability to practice medicine with reasonable skill and safety to patients as a result of said impairment, the following procedure should be used.
- b. To ensure optimum patient care and safety as well as the safety and health of practitioners.

Section 2. Identification of "Impairment"

- a. An "impairment" is any condition, whether temporary or permanent, which may affect or provide a risk of affecting a practitioner's ability to practice medicine or his or her profession with reasonable skill and safety to patients and fellow practitioners or personnel as a result of said impairment. Impairment includes but is not limited to conditions such as chemical dependence, mental illness, and some physical illnesses.

Section 3. Reporting of Suspected Impairment

- a. A practitioner believing he or she has an impairment should approach the chairperson of his/her primary clinical department. If any individual working in the hospital reasonably suspects that a practitioner is impaired, he/she shall make a report, preferably in writing, to the chairperson of the practitioner's primary clinical department or Chief Executive Officer or designee. The report should state the facts underlying said suspicion in as much detail as possible.
- b. If the chairperson of the practitioner's primary clinical department receives the report, he or she will notify the Chief Executive Officer or designee who will notify the President of the Medical Staff.
- c. The practitioner will be provided an opportunity to discuss the situation with the Executive Officers of the Medical Staff, Chief Executive Officer or designee and the chairperson of the affected practitioner's primary clinical department before a plan of action is considered, if indicated. Said discussion should include an opportunity for the practitioner to make suggestions for this plan. This discussion does not constitute a hearing pursuant to Article IX of the Medical Staff Bylaws.
- d. Any combination of the following may be incorporated into an accommodation/rehabilitation plan, but not limited to:
 1. Reduction of privileges;
 2. Suspension of privileges until completion of specific conditions or requirements;

3. Counseling approved by the Hospital;
4. Enrollment in or successful completion of a rehabilitation program approved by the Hospital (or that has been approved by the Board of Medical Examiners if it has also taken action);
5. Monitoring;
6. Approval by designated physicians or other professionals as to the practitioner's ability to practice effectively and safely;
7. Successful passage of testing for drugs, alcohol or other applicable testing programs which comply with State and Federal law;
8. Provision of and use of devices which eliminate or obviate any physical impairment in accordance with State and Federal law;
9. Disclosure of information and opinions relating to said condition and requested by the Hospital as allowed by law; and

Section 4. Action

- a. After the aforementioned discussion with the practitioner, the accommodation/rehabilitation plan should be placed in writing and formal approval received by the practitioner involved, President of the Medical Staff, chairperson of the practitioner's primary clinical department and the Chief Executive Officer or designee.
- b. If the practitioner does not agree with the plan, the same procedures afforded a practitioner in corrective actions will be used in accordance with Article VIII in these Bylaws.
- c. The plan shall address consequences for failure to comply, including corrective action. The plan shall also address how reinstatement shall be accomplished in situations where privileges have been reduced.
- d. Documents associated with this process will be maintained as peer review documents to the extent allowed by law and not be released except as required or allowed by law.
- e. Notwithstanding any of the foregoing, nothing shall preclude the Hospital from taking any action necessary to preserve patient care and safety including summary suspension and other disciplinary action.

VIII: CORRECTIVE ACTION

Section 1. Procedure

- a. The final responsibility for patient care is carried by the physician, and appropriate actions to insure that this case is given is also the responsibility of the physician; however, no such action can be conducted in a disruptive manner.
- b. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital (Policy #8720.1001.0, Disruptive Behavior Involving Practitioners, Rules & Regulations, Section L), corrective action against such practitioner may be requested by any member of the Medical Staff, any appropriate Medical Staff Committee, by the Chief Executive Officer or the Governing Board. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request. All such requests must be signed by the person or persons making the request. A request for corrective action is considered to have been officially received at the time of the next Executive Committee meeting following the submission in writing of such a request to any officer of the Medical Staff.
- c. The Executive Committee shall review such requests and after evaluation, forward it within ten (10) days of receipt to the Department Chair wherein the practitioner has such privileges, if appropriate. If the Executive Committee determines the corrective action requested does not require an Ad Hoc Committee, the Executive Committee must meet with the individual requesting the corrective action to state the reasons for denying the request. If the individual requesting the corrective action does not agree and still requests a corrective action take place, the Executive Committee will then be obligated to follow the process. At the same time that the Department Chair involved is notified, the physician against whom the corrective action has been proposed should also be notified, stating the nature of the complaint. The source (individual or committee) initiating the corrective action shall also be identified. Upon receipt of such request, the Department Chairman shall immediately appoint an Ad Hoc Committee to investigate the matter.
- d. Within forty (40) days of the initial receipt of the request for corrective action, the Department shall make a report of its investigation to the Executive Committee. Prior to making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Department Ad Hoc Investigating Committee of which the Chief Executive Officer shall be an ex officio member. At such interview, he/she shall be informed of the general nature of the charges against him/her, and shall be invited to discuss, explain or refute them. The person requesting the corrective action must attend this interview unless excused by the president of the Medical Staff. This interview shall not constitute a hearing,

shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the Department and included with its report to the Executive Committee.

- e. Within seventy (70) days of the initial receipt of the request for corrective action, and following the department investigation of a request for corrective action involving reduction or suspension of clinical privileges, the Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto. A record of such appearance shall be made by the Executive Committee.
- f. The action of the Executive Committee on a request for corrective action may be to reject or modify the request for corrective action; to issue a warning or a letter of admonition, or a letter of reprimand; to impose terms of probation or a requirement for consultation; to recommend reduction, suspension or revocation of clinical privileges; to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or to recommend that the practitioner's Staff membership be suspended or revoked.
- g. Any recommendations by the Executive Committee for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff must be approved by the General Medical Staff at a meeting of the general Medical Staff -- either a regularly scheduled or a special meeting.
- h. If the recommendation is approved, this shall entitle the affected practitioner to the procedural rights provided in Article IX of these Bylaws.
- i. The President of the General Medical Staff shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the General Medical Staff and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith. After the General Medical staff has made its recommendations in the matter, the procedure to be followed shall be as provided in Article V, Section 2, and in Article IX, if applicable, of these Bylaws.

Section 2. Summary Suspension

- a. The President of the Medical Staff or his/her designee, or the President Elect/Vice President if neither the President or his/her designee are available, the Chief Executive Officer or the Governing Board shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner and such summary suspension shall become effective immediately upon imposition.

- b. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Executive Committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the Executive Committee may be convened in accordance with Article IX of these Bylaws.
- c. The Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Executive Committee does not recommend immediate termination of the summary suspension, the General Medical Staff must approve this at a regular or a specially called meeting. If the General Medical Staff approves, the affected practitioner shall, also in accordance with Article IX of these Bylaws, be entitled to request an appellate review by the Governing Board, but the terms of the summary suspension as sustained or modified by the General Medical staff shall remain in effect pending a final decision thereon by the Governing Board.
- d. Immediately upon the imposition of a summary suspension, the president of the General Medical Staff or responsible Chief of Service shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

Section 3. Automatic Suspension/Termination

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. The following events shall result in automatic suspension or termination of a Practitioner's Medical Staff membership or Clinical Privileges, as specified, without right to Due Process.

PROFESSIONAL LICENSE

A Practitioner whose license to practice a health profession in the State of Iowa is suspended, restricted or lapsed shall automatically be suspended from practicing in the Hospital. If a Practitioner's health profession license in the State of Iowa is revoked or otherwise terminated, or is suspended, restricted or lapsed for more than thirty (30) consecutive days, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION OR STATE CONTROLLED SUBSTANCES LICENSE

A Practitioner whose DEA registration or Iowa controlled substances 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 Executive Committee shall convene to review and consider the

facts under which the DEA registration or controlled substances license was revoked, suspended, restricted or lapsed. The Medical Executive Committee shall then take such further action, if any, pursuant to Article VII or VIII, as the Medical Executive Committee determines appropriate.

MEDICAL RECORDS

In accordance with the Rules, an automatic suspension of a Practitioner's Clinical Privileges shall be imposed for failure to complete medical records within the periods described in the rules.

MALPRACTICE INSURANCE

A Practitioner who fails to provide the Hospital with adequate evidence of a professional liability insurance required by the Board of Directors shall be automatically suspended from practicing in the Hospital. If the Practitioner fails to provide the Hospital with adequate evidence of the required insurance within ninety (90) days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

FEDERAL PROGRAM EXCLUSION

Exclusion of a Practitioner from a federal health care program shall cause an automatic termination of the Practitioner's Medical Staff membership and Clinical Privileges. (The terms of this Section do not apply to the voluntary decision by a Practitioner not to participate in federal health care program(s).)

DUES

If a Medical Staff Member fails to pay Medical Staff dues within ninety (90) days after the dues date, the Member's Clinical Privileges shall be suspended automatically until dues are paid in full. If a Member fails to pay Medical Staff dues for more than thirty (30) days after the due date, the Member's Medical Staff membership and Clinical Privileges shall terminate automatically.

LEAVE OF ABSENCE

Failure to submit a timely request for reinstatement from a leave of absence or failure to provide a summary of activities during a leave of absence or other information requested or required will result in automatic termination of Medical Staff membership and Clinical Privileges as provided in Section 2.6.

IX: HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and to Appellate Review

- a. When any practitioner with clinical privileges receives notice of recommendation of the General Medical Staff that, if ratified by decision of the Governing Board, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before an Ad Hoc Committee of the Medical Staff. If the recommendation of an Ad Hoc Committee of the General Medical Staff following such hearing is still adverse to the affected practitioner, he/she shall then be entitled to an Appellate Review by the Governing Board before the Governing Board makes a final decision on the matter.
- b. When any practitioner receives notice of a decision by the Governing Board that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the General Medical Staff with respect to which he/she was entitled to a hearing and appellate review, he/she shall be entitled to a hearing by a Committee appointed by the Governing Board, and if such hearing does not result in a favorable recommendation, to an Appellate Review by the Governing Board before the Governing Board makes a final decision in the matter.
- c. All Hearings and Appellate Reviews shall be in accordance with the procedural safeguards set forth in this Article IX to assure that the affected practitioner is accorded all rights to which he/she is entitled.

Section 2. Notice of Proposed Action

- a. The Chief Executive Officer shall be responsible for giving a prompt written Notice of Proposed Action based upon an adverse recommendation of the General Medical Staff or any decision to any affected practitioner, who is entitled to a hearing, or to an Appellate Review, by certified mail, return receipt requested.

The notice shall include a summary of the reasons for the proposed action, notice of the right to request a hearing on the proposed action within thirty (30) days of the receipt of notice and a summary of the rights of the affected practitioner in such a hearing. A copy of the Bylaws shall also be provided to the affected practitioner.

- b. The failure of a practitioner to request a hearing to which he/she is entitled by these Bylaws within thirty (30) days from receipt of the Notice of Proposed Action, an adverse recommendation or any decision effecting the practitioner in the manner herein provided shall be deemed a waiver of his/her right to such Hearing and to any Appellate Review to which he/she might otherwise have been entitled on the matter. The failure of a practitioner to request an Appellate Review to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such Appellate Review on the matter.

- c. When the waived Hearing or Appellate Review relates to an adverse recommendation of the General Medical Staff or of a Hearing Committee appointed by the Governing Board, the same shall thereupon become and remain effective against the affected practitioner pending the Governing Board's decision on the matter. When the waived hearing or Appellate Review relates to adverse decision by the Governing Board, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Governing Board provided for in Section 7 of this Article IX. In either of such events, the Chief Executive Officer shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

Section 3. Notice of Hearing

- a. Within seven (7) days after receipt of a request for hearing from the affected practitioner, the Executive Committee or the Governing Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, send a Notice of Hearing to the affected practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall be not less than thirty (30) days after the date of receipt of the Notice of Hearing by the affected practitioner.
- b. In addition to the date, time and place of the hearing, the Notice of Hearing shall state in concise language the acts or omissions of the affected practitioner which are the basis for the adverse recommendation or decision and a list of witnesses who may be called at such hearing.

Section 4. Composition of Hearing Committee

- a. When a Hearing relates to an adverse recommendation of the General Medical Staff, such hearing shall be conducted by an Ad Hoc Hearing Committee of not less than four (4) members of the Medical Staff appointed by the President of the Medical Staff in consultation with the Executive Committee, and one of the members so appointed shall be designated as Chairman. The members of the Ad Hoc Hearing Committee shall not include an individual who is in direct economic competition with the affected physician. Additionally, no staff member who has actively participated in the consideration of the adverse recommendation shall be appointed as a member of this hearing Committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.
- b. When a hearing relates to an adverse decision of the Governing Board that is contrary to the recommendation of the General Medical staff, the Governing Board shall appoint a Hearing committee to conduct such hearing and shall designate one of the members of this committee as Chairman. At least one representative of the Medical Staff who is not in direct economic competition with the affected practitioner shall be included on this committee when feasible.

Section 5. Conduct of Hearing

- a. There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place and no member may vote by proxy.
- b. An accurate record of the hearing shall be kept through the use of a court reporter.
- c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2 of this Article IX and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2 of this Article.
- d. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Ad Hoc Hearing Committee. Granting of such postponements shall only be for good cause shown and within the sole discretion of the Hearing Committee.
- e. In the hearing, the affected practitioner has the right:
 - 1. To be represented by an attorney or other person of his/her choice;
 - 2. To have a record made of the proceedings and to obtain a copy of the record of such proceedings upon the payment of reasonable costs;
 - 3. To call, examine and cross-examine witnesses;
 - 4. To present evidence determined to be relevant by the hearing committee;
 - 5. To submit a written statement at the close of the hearing; and
 - 6. Upon the completion of the hearing to receive a written recommendation of the Hearing Committee or Hearing Officer, including a statement of the basis for the recommendation and to receive a written decision of the Board, including a statement of the basis for the decision.
- f. Either a Hearing Officer, if one is appointed, or the Chairman of the Hearing Committee, or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
- g. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The affected practitioner shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall

become a part of the hearing record.

- h. A committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff Member or represent it at the hearing to present the facts in support of its adverse recommendation and to call and examine witnesses. The Governing Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing to present the facts in support of its adverse decision and to call and examine witnesses. It shall be the obligation of such representative to present appropriate evidence showing that the charges or ground involved are supported by a factual basis and or that such basis or any action based thereon is not arbitrary, unreasonable or capricious.
- i. If the affected practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination. It shall be the obligation of the affected practitioner to present appropriate showing that the charges or grounds involved may lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.
- j. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence. Upon conclusion of the presentation or oral or written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the affected practitioner.
- k. Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Governing Board, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Governing Board. A copy of such report and recommendation shall be sent to the affected practitioner by certified mail, return receipt requested.

Section 6. Appellate Review by the Governing Board

- a. Within seven (7) days after receipt by an affected practitioner of a decision of the Hearing Committee in which an adverse recommendation or decision made or adhered to after a hearing as above provided, he/she may, by written notice to the Governing Board delivered through the Chief Executive Officer by certified mail, return receipt requested, request an Appellate Review by the Governing Board. Such notice may request that the Appellate Review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of Appellate Review.

- b. If such Appellate Review is not requested within seven (7) days, the affected practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of Article IX.
- c. Within seven (7) days after receipt of such Notice of Request for Appellate Review, the Governing Board shall schedule a date for such review including a time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the Appellate Review shall not be less than twenty-one (21) days, nor more than sixty (60) days, from the date of receipt of the Notice of Request for Appellate Review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than seven (7) days from the date of receipt of such notice.
- d. The Appellate Review shall be conducted by the Governing Board or by a duly appointed Appellate Review Committee of the Governing Board of not less than four (4) members.
- e. The affected practitioner shall have access to the report and record (and transcription, if any) of the ad hoc committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. He/she shall have twenty-one (21) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Board through the Chief Executive Officer by certified mail, return receipt requested, at least twenty-one (21) days prior to the scheduled date for the Appellate Review. A similar statement may be submitted to the General Medical Staff or by the Chairman of the Hearing Committee appointed by the Governing Board, and if submitted, the Chief Executive Officer shall provide a copy thereof to the practitioner at least twenty-one (21) days prior to the date of such Appellate Review by certified mail, return receipt requested.

- f. The Governing Board or its appointed review committee shall act as Appellate Review Body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to Subparagraph e. of this Section 6, for the purposes of determining whether the adverse recommendation or decision against the affected practitioner was justified and not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such Appellate Review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the Appellate Review Body. The General Medical Staff or the Governing Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the Appellate Review Body.
- g. New or additional matters not raised during the original Hearing or in the Hearing Committee Report, nor otherwise reflected in the record, shall only be introduced at the Appellate Review under unusual circumstances, and the Governing Board or the committee thereof appointed to conduct the Appellate Review shall within its sole discretion determine whether such new matters shall be accepted.
- h. If the Appellate Review is conducted by the Governing Board, it may affirm, modify or reverse its prior decision, or within its discretion, refer the matter back to the General Medical Staff for further review and recommendation with fourteen (14) days. Such referral may include a request that the General Medical Staff arrange for a further hearing to resolve specified disputed issues.
- i. If the Appellate Review is conducted by a Committee of the Governing Board, such committee shall, within fourteen (14) days after the scheduled adjourned date of the Appellate Review, either make a written report recommending that the Governing Board affirm, modify or reverse its prior decision, or refer the matter back to the General Medical Staff for further review and recommendation within thirty (30) days. Such referral may include a request that the General Medical Staff arrange for a further hearing to resolve disputed issues. Within forty-five (45) days after the receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Board as above provided.
- j. The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Governing Board may be taken by a committee of the Governing Board duly authorized to act.

Section 7. Final Decision by Governing Board

- a. Within thirty (30) days after the conclusion of the Appellate Review, the Governing Board shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Chief Executive Officer, to the affected

practitioner, by Certified Mail, return receipt requested. If this decision is in accordance with the General Medical Staff's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or Appellate Review. If this decision is contrary to the General Medical Staff's last such recommendation, the Governing Board shall refer the matter to the Executive Committee for further review and recommendation within thirty (30) days and shall include in such notice of its decision a statement that a final decision will not be made until the Executive Committee's recommendation has been received. At its next meeting after receipt of the Executive Committee's recommendation, the Governing Board shall make its final decision with like effect and notice as first above provided in this Section 7.

- b. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one Appellate Review on any matter which shall have been the subject of action by the General Medical Staff, or by a duly authorized committee of the Governing Board or by both, unless, or and if additional evidence, information and testimony may have altered the first review and was not available or made known at that time.

X: OFFICERS

Section 1. Officers of the Medical Staff

- a. The Officers of the Medical Staff Shall be:
1. President
 2. President Elect/Vice President
 3. Secretary-Treasurer

Section 2. Qualifications of Officers

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term in office. Failure to maintain such status shall immediately create a vacancy in the office involved. The President and Vice President/Elect must be physicians with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Staff activities.

Section 3. Nominations

The nominations for Staff Officers is initiated by a mail survey of the staff for those who are willing to be considered for an active staff office.

Section 4. Election of Officers

A ballot listing each active staff physician who is willing to be considered will be sent out to the Medical Staff and they will be allowed to vote for the one person for President of the Medical Staff. The ballot will be contained in an envelope on which the name of the voting physician is typed and on which there is space for the voting physician's signature. The physician's signature is required for the vote to be valid. A deadline for returning the ballot will be established.

The ballots will be counted by two (2) non-physicians designated by the President of the Medical Staff and voting confidentiality will be maintained. Once the ballots are counted, the top three (3) vote-getters will be placed on a ballot and again presented to the Medical Staff, by mail, for a final vote.

The ballots will then be counted by the designated individuals, again maintaining strict confidentiality of voting.

The person with the highest number of votes would then be President of the Medical Staff, the second top vote-getter would then be Vice-President/President-Elect, and the third top vote-getter would then be the Secretary/Treasurer.

The term of President would be for one (1) year and the Vice-President/President-Elect would

automatically become the President the next year.

An election is then held yearly for the Vice President/ President-Elect and Secretary/Treasurer by the above protocol, except that after the initial vote and the top three (3) vote-getters are determined when the balloting is carried out; the highest vote-getter will become the Vice President/President-Elect and the second highest vote-getter will become the Secretary/Treasurer. In the event of a tie vote, another ballot will be cast and voted upon by the membership.

Section 5. Exceptions

Sections 3 and 4 shall not apply to the Office of President. The Vice President shall, upon the completion of his/her term of office in that position, immediately succeed to the office of President.

Section 6. Term of Elected Office

Each officer shall serve a one-year term commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected.

Section 7. Conditions for and Removal of Staff Officers

Except as otherwise provided, removal of an elected Staff Officer may be initiated by the Governing Board acting upon its recommendation and effected by a two-thirds vote of the total members of the Active Medical Staff. Conditions for removal include failure to maintain Active Staff privileges and failure to perform duties as outlined in Section 9.

Section 8. Vacancies in Elected Office

Vacancies in offices, other than those of President and Vice President, shall be filled by the Medical Staff Executive Committee. If there is a vacancy in the Office of President, the Vice President shall serve the remaining term. A vacancy in the Office of Vice President shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible following the general mechanism outlines in Sections 3 and 4.

Section 9. Duties of Elected Officers

- a. President: The President shall serve as chief administrative officer and principal elected official of the Medical Staff. As such, he/she shall:
 1. Aid in coordinating the activities and concerns of Hospital administration and of the nursing and other patient care services with those of the Medical Staff.
 2. Be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance

within the Hospital and for the effectiveness of the patient care audit and other quality improvement function delegated to the Medical Staff.

3. Develop and implement, in cooperation with department chairmen, methods for credentials review and for delineation of privileges; continuing education programs, utilization management, concurrent monitoring of practice, and retrospective patient care review.
 4. Appoint the medical staff representatives to Medical Staff and Hospital management committees, subject to the approval of the Executive Committee.
 5. Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Governing Board, the Chief Executive Officer and other officials of the Hospital staff.
 6. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
 7. Call, preside at and be responsible for the agenda of all general meetings of the Medical Staff.
 8. Serve as Chairman of the Medical Staff Executive Committee and ex officio member of all other Medical Staff committees.
- b. Vice President: The Vice President shall be a member of Executive Committee. In the temporary absence of the President, shall assume all the duties and have the authority of the President. Shall perform such additional duties as may be assigned by the President or the Medical Staff Executive Committee.
- c. Secretary-Treasurer: The Secretary-Treasurer shall be a member of the Medical Staff Executive Committee. His/her duties shall be to:
1. Give proper notice of all Medical Staff meetings on order of the appropriate authority.
 2. Approve accurate and complete minutes for all meetings.
 3. Supervise the collection and accounting for any funds that may be collected in the form of dues, assessments or application fees.

Section 10. Additional Officers

The Governing Board may, after considering the advice and recommendations of the Medical Staff, appoint additional practitioners to medico-administrative positions within the Hospital to

perform such duties as prescribed by the Medical Staff Executive Committee as prescribed by the Medical Staff Executive Committee and the Governing Board or as defined by amendment to the Bylaws. To the extent that any such officer performs any clinical function, he/she must become and remain a member of the Medical Staff. In all events, he/she must be subject to these Bylaws and to the other policies of the Hospital.

Any physician whose engagement by the Hospital requires membership on the Medical Staff shall not have his/her medical staff privileges terminated without the same due process provisions as must be provided for any other member of the Medical Staff. Provisions of termination of the physician-administrative responsibilities will be addressed in the contract document.

XI: STAFF DEPARTMENTS

Section 1. Organization of Staff Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a Chair and Vice Chair, who is elected and has the authority, duties and responsibilities as specified in this Article.

Section 2. Designation

a. Current Departments:

The current departments are: Internal Medicine, Surgery, OB/GYN, Pediatrics, and Family Practice.

b. Future Departments:

When deemed appropriate, the Medical Staff Executive Committee and the Governing Board, by their joint action, may create new, eliminate, subdivide, further subdivide or combine departments.

Section 3. Assignment to Departments

Each member of the Medical Staff shall be assigned membership in at least one department in which the practitioner is significantly active, and which shall be designated as the member's primary department, but may be granted membership and/or clinical privileges in one or more of the other departments, as a primary member, and in connection with matters requiring the vote of department members, Medical Staff members may vote only in their designated primary department. The exercise of clinical privileges within any department shall be subject to the rules and regulations of that department and the authority of the department chairman.

Section 4. Functions of Departments

The primary responsibility delegated to each department is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

- a. Conduct patient care review for the purposes of analyzing, reviewing and evaluating the quality of care within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Staff Executive Committee, but shall not be less than the number currently required by the Joint Commission on Accreditation of Healthcare Organizations or, if higher, the number required by law. Each department shall review the clinical work performed under its jurisdiction whether or not any particular practitioner whose work is subject to such review is a member of that department. The Department of Surgery has jurisdiction

over all activities occurring within the Operating Room.

- b. Establish guidelines for the granting of clinical privileges within the department and submit the recommendations required under Article VI regarding the specific privileges each Medical Staff member or applicant may exercise and the specified services that each health professional affiliate may provide.
- c. Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in state of the art and to findings or reviews and evaluation activities.
- d. Monitor on a continuing and concurrent basis adherence to:
 - 1. Staff and Hospital policies and procedures;
 - 2. Requirements for alternate coverage and for consultations;
 - 3. Sound principles of clinical practice;
 - 4. Fire and other regulations designed to promote patient safety.
- e. Coordinate the patient care provided by the department members with nursing and ancillary patient care services and with administrative support services.
- f. Foster an atmosphere of professional decorum within the department appropriate to the healing arts.
- g. Submit written reports to the Medical Staff Executive Committee on a regularly scheduled basis concerning:
 - 1. Findings of the department's review and evaluation activities, actions taken thereon and the results of such action;
 - 2. Recommendations for maintaining and improving the quality of care provided in the department and the Hospital;
 - 3. Such other matters as may be requested from time to time by the Medical Staff Executive Committee.
 - 4. The minutes of the meetings shall be recorded by a designated recorder who is acceptable to both the General Medical Staff and to the Administration. Such recorder, if not an Active Medical Staff Member and not a Chief Executive Officer, may be asked to leave the room at any time upon a recommendation of the majority of the department members present. It shall then be the obligation of the chairman of the meeting to be sure that the minutes are recorded accurately.

- h. Meet a minimum of six times a year for the purpose of receiving, reviewing and considering patient care findings and the results of the department's other review, evaluation and education activities, and of performing or receiving reports on other department and staff functions.
- I. Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.
- j. Establish, if necessary, an **on call schedule** to ensure that medical coverage is available on a particular service at all times. (See Article IV, Section 2.)
- k. Review surgical cases in which a specimen was removed as well as those cases where no tissue was removed. The review shall include the indications for surgery and those cases in which there is a major discrepancy between the preoperative and post-operative diagnosis. A screening mechanism based on established criteria may be established.
- l. Review of blood transfusions for proper utilization. Special emphasis shall be given to the use of whole blood transfusions versus component blood elements.
- m. Evaluate any transfusion reactions.
- n. Conduct, coordinate and review quality improvement activities pertinent to the departments.

Section 5. Emergency Services

Emergency Room physicians who hold Active Staff status shall be members of the Emergency Services Committee. The Emergency Services Committee as described in Article XII, Section 5 shall fulfill the functions of Article XI, Section 4 (a-n).

Section 6. Department Chairs

- a. **Qualifications:** Each Department Chair and Vice Chair shall be a member in good standing of the Active Staff for a minimum of one year, shall be board certified or demonstrate comparable competence through the credentialing process in at least one of the clinical areas covered by the department, and shall be willing and able to faithfully discharge the functions of his/her office.
- b. **Election and term of Office:** Department Chairs and Vice Chairs shall serve a two-year term commencing on his/her election. He/She shall serve until the end of the succeeding Medical Staff year and until a successor is chosen. He/she shall be elected by the majority of those eligible to vote in his/her department.

A Department Chair or Vice Chair shall be eligible to succeed himself/herself but may serve no more than two (2) consecutive full terms in office. Removal of a Department

Chair or Vice Chair from office may be initiated by the Governing Board acting upon its own recommendation or upon the recommendation of the Medical Staff Executive Committee with the concurrence of the Governing Board, or upon the vote of 50 percent of those eligible to vote in his/her Department.

- c. A Department Chair or Vice Chair shall not hold a Medical Staff Officer position while he/she is a Department Chair.
- d. In the absence of the Department Chair, the Vice Chair will assume the duties and responsibilities of the Department Chair.
- e. Duties: Each Chair and/or Vice Chair shall:
 1. Account to the Medical Staff Executive Committee for professional and administrative activities within his/her department, and particularly for the quality of patient care rendered by members of his/her department, and the effective conduct of the performance evaluation and other quality maintenance functions delegated to his/her department.
 2. Develop and implement departmental program, in cooperation with the President of the Staff and consistent with the provisions of these Bylaws for credential review and privileges delineations, utilization management, concurrent monitoring of practice, and retrospective patient care review. As needed, assist Administration with the orientation and continuing medical education programs.
 3. Be a member of the Medical Staff Executive Committee, thereby integrating the department into the primary function of the organization through coordination and integration of interdepartmental and intradepartmental services. Give guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding his/her own department.
 4. Maintain continuing review of the professional privileges and of all affiliates with specified services in his/her department and report regularly thereon to the Medical Staff Executive Committee.
 5. Transmit to the appropriate authorities as required by the Bylaws, his/her department's recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services and corrective action with respect to practitioners in his/her department.
 6. Appoint such committees as are necessary to conduct the functions of the department and designate a Chairman and Secretary for each.
 7. Enforce the Hospital and Medical Staff Bylaws, Rules and Regulations and Policies within his/her department, including initiating corrective action and

investigation of clinical performance and ordering required consultation.

8. Implement within his/her Department actions taken by the Medical Staff Executive Committee and by the Governing Board.
9. Participate in every phase of administration of the department through cooperating with Nursing Services and Administration in matters affecting patient care, including personnel, supplies, space and other resources, special regulations, standing orders and techniques. Assess and recommend to the Executive Committee off-site sources for needed patient care services not provided by the organization.
10. Assist in the preparation of such annual reports including budgetary planning pertaining to his/her department as may be required by the Medical Staff Executive Officer, the Chief Executive Officer, or the Governing Board.
11. Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the President of the Medical Staff, the Medical Staff Executive Committee or the Governing Board.

XII: COMMITTEES

Section 1. Committees

- a. Committees shall be Standing and Special. All committees except the Executive Committee shall be appointed by the President of the Medical Staff, subject to the approval of the Medical Staff Executive Committee. All committee appointments will be for a period of one year. No policies of any committee shall be final until approved by the Medical Staff Executive Committee.
- b. **Standing Committees** shall be:
 - Executive Committee
 - Bylaws Committee
 - Credentials Committee
 - Emergency Services Committee
 - Pharmacy Therapeutics/Infection Control Committee
 - Utilization Management Committee
 - Medical Records Committee
 - Medical Education/Library Committee
 - Radiation Safety Committee
 - Critical Care Committee
 - Peer Review Committee
- c. **Special Committees** will be Ad Hoc Committees appointed by the President of the Medical Staff, subject to approval by the Medical staff Executive Committee. Special Committees should confine their work to the purpose for which they were appointed and should report to the General Medical Staff or the Medical Staff Executive Committee, depending on which group originated the committee. They shall have no power to act, except where specifically granted by the motion originating the committee. Special Committees can be appointed by the President, General Medical staff, Medical Staff Executive Committee and by any Standing Committee or any Departmental Chairman.
- d. The President shall select his/her committee selections, to be subsequently approved by the Medical Staff Executive Committee. This shall be accomplished by the end of the first month in office.
- e. Any General Medical Staff member can request a change in personnel on a committee which he/she feels is not functioning properly or fairly. This request should be made to the Medical Staff Executive Committee which will consider the request. The decision of the Medical Staff Executive Committee is final.
- f. Unless otherwise stipulated, all non-physician members of Medical Staff Committees shall be nonvoting members.

- g. The minutes of the meeting should be recorded by a designated recorder who is acceptable to both the General Medical Staff and to the Administration. Such recorder, if not an Active Medical Staff member and not a Chief Executive Officer, may be asked to leave the room at any time upon a recommendation of the majority of the committee members present. It shall then be the obligation of the Chairman of the meeting to be sure that the minutes are recorded accurately.

Section 2. Executive Committee

- a. Composition: the Executive Committee shall be a standing Committee and shall consist of the Officers of the Medical Staff and the Chairman or Vice Chairman of each clinical department.
- 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 various departments.
 3. To approve committee assignments and to receive and act upon committee reports.
 4. To implement policies of the Medical Staff not otherwise the responsibilities of the services. Decisions of the General Medical Staff are final and may not be overturned by the Executive Committee.
 5. To provide liaison between Medical Staff and the Chief Executive Officer and the Governing Board.
 6. To recommend action to the Chief Executive Officer on matters of a medical-administrative nature.
 7. To make recommendations on Hospital management matters (for example, long-range planning).
 8. To insure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.
 9. To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.
 10. To review the recommendations of the department on the credentials of all applicants and to make recommendations for staff membership, assignments to departments, and delineation of clinical privileges to the Governing Board.

11. To review periodically all information available particularly the recommendations of the Credentials Committee regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges.
 12. To take all reasonable steps to insure professional 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.
 13. The organization of the quality improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities.
 14. To report at each General Staff meeting.
 15. In such cases as the Bylaws may inadvertently cause undue hardship such as prohibiting or limiting the Hospital practice of a physician, the Executive Committee of the Medical Staff by a positive vote, along with the Executive Committee of the Governing Board, may allow remedy on a temporary basis until such time as the General Staff may be able to address the issue.
- c. Meetings: The Executive Committee shall meet a minimum of every other month and maintain a permanent record of its proceedings and actions.
 - d. Quorum: The presence of fifty percent (50 percent) of the members constitutes a quorum.

Section 3. Medical Staff Bylaws Committee

- a. Composition: This committee shall consist of at least three Medical Staff members.
- b. Duties: This committee shall be responsible for making recommendations relating to revisions and updating of the Bylaws, Rules and Regulations of the Medical Staff. The committee shall conduct a comprehensive review of the Bylaws, Rules and Regulations at least every three years.
- c. Meetings: The committee shall meet as needed.

Section 4. Credentials Committee

- a. Composition: This committee shall consist of at least three Medical Staff members.
- b. Duties: The Credentials Committee shall be responsible for:
 1. Investigation of the credentials of all applicants for membership or

reappointment to the General Medical Staff and to make recommendations to the Executive Committee in accordance with these Bylaws.

2. Reviewing all information available regarding the competence of Medical Staff members and as a result of such review, make recommendations to the Executive Committee for the granting of privileges and assignment to various departments as provided in these Bylaws.
 3. Seeking the advice of any practitioner or department in coming to a decision on a recommendation for appointment, reappointment or denial of privileges.
- c. Meetings: The committee shall meet a minimum of six times a year.

Section 5. Emergency Services Committee

- a. Composition: The Emergency Services Committee should consist of members of the Medical Staff, Nursing Services, and Administration. All Emergency Room physicians are also members of this committee. Appointment of Nursing Service members and Administrative members shall be made after consultation with the Chief Executive Officer. The Chairman shall act as Director of Emergency Services.
- b. Duties: The Emergency Services Committee Shall:
 1. Provide liaison between the Hospital, Medical Staff and area Emergency Medical Service providers.
 2. Coordinate the Medical Staff's participation in the Hospital's External and Internal Disaster Plans.
 3. Fulfill the responsibilities of reviewing professional activities, recommending privileges, and insuring quality medical care as outlined in Article X, Section 4 (a-n). The committee's Chairman shall be responsible for the same duties as a Department Chairman as outlined in Article X, Section 6 (d) (1-11).
- c. Meetings: The committee shall meet a minimum of six times a year, and a quorum shall be necessary to conduct business. The quorum requirement shall be determined by the Emergency Services Committee.

Section 6. Pharmacy Therapeutics/Infection Control Committee

- a. Composition: The voting members of the Pharmacy Therapeutics/Infection Control Committee shall consist of three members of the Medical Staff appointed to this committee having an active interest in pharmacy therapeutics/infection control and representing the various Hospital Medical Staff Departments. In addition, nonvoting membership shall include the Chief Pharmacist of the Hospital, Hospital Infection Control Nurse, another representative of Nursing Services, a representative of the

Microbiology Section of Laboratory Services and a representative of Hospital Administration. Representation from Housekeeping, Central Services, Laundry, Dietary, Maintenance, Pharmacy and the Operating Room shall be available on a consultative basis. All appointments of Hospital personnel shall be made in conjunction with the Chief Executive Officer.

- b. Duties: The duties of the Pharmacy Therapeutics/Infection Control Committee shall be:
1. Develop and maintain surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum of potential 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.
 2. Serve as an advisory group to the Medical Staff and the Pharmacist on matters pertaining to the choice of available drugs.
 3. Make recommendations concerning drugs to be stocked on the nursing units and by other services.
 4. Develop and review periodically a formulary or drug list for use in the Hospital.
 5. Prevent unnecessary duplication in stocking drugs and drug combinations having identical amounts of the same therapeutic ingredients.
 6. Evaluate clinical data concerning the use and control of investigational drugs and of research in the use of recognized drugs.
 7. Establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs.
 8. Maintain surveillance of inadvertent Hospital infection potentials.
 9. Review and analyze actual infections.
 10. Promote a preventive and corrective program designed to minimize infection hazards.
 11. Supervise infection control in all phases of the Hospital's activities including: operating rooms, delivery rooms, recovery rooms, special care units, sterilization procedures by heat, chemicals or otherwise, isolation procedures, prevention of cross infection by anesthesia apparatus or inhalation therapy equipment, testing of Hospital personnel for carrier status, disposal of infectious material, and other situations as requested by the Medical Staff Executive Committee or Chief

Executive Officer.

12. Institute such measures as necessary in an emergency, upon approval of the President of the Medical Staff and the Chief Executive Officer.
 13. Establish criteria and review the clinical use of antibiotics for all patients served by the Hospital. This review shall include both the therapeutic and prophylactic use of antibiotics.
 14. Maintain a permanent record of all activities relating to infection control and antibiotic usage.
 15. Submit periodic reports to the Medical Staff Committee, Chief Executive Officer and the Vice President of Nursing.
- c. Meetings: The committee shall meet a minimum of four times a year.

Section 7. Utilization Management Committee

- a. Composition: The Utilization Management Committee shall consist of at least four members of the General Medical Staff. The Utilization Management Coordinator shall serve on the committee in an ex officio capacity as well as other Hospital personnel deemed appropriate by the Chief Executive Officer. The Utilization Management Coordinator and other Hospital personnel will be nonvoting members of this committee.
- b. Duties: The duties of the Utilization Management Committee shall be to:
 1. Conduct utilization management studies designed to evaluate the appropriateness of admission to the Hospital, length of stay, discharge practices, use of medical and Hospital services, and all related factors which may contribute to the effective utilization of Hospital and physician services.
 2. Formulate a written utilization management plan for the Hospital. Such a plan as approved by the General Medical Staff and Governing Board must include the following:
 - a. Delineation of responsibilities for performing utilization management activities including Medical Staff, non-physician health care professionals and administrative personnel.
 - b. Conflict of interest policy.
 - c. Confidentiality policy.
 - d. Methods of identification of over-utilization or under-utilization of

Hospital services.

- e. Procedures for conducting concurrent as well as retrospective reviews and a discharge planning mechanism.
- 3. Review and evaluate the Utilization Management Plan at least on an annual basis.
- 4. Maintain appropriate records and make periodic reports to the Medical Staff Executive Committee and Governing Board.
- c. Meetings: The committee shall meet a minimum of three times a year.

Section 8. Medical Records Committee

- a. Composition: The Medical Records Committee shall consist of at least four members of the Medical Staff from various departments. In addition, the committee membership shall include the Director of Medical Record Services, a representative of Nursing Services and a representative of Administration. The Hospital representative shall be appointed after consultation with the Chief Executive Officer.
- b. Duties: The duties of the committee shall be to:
 - 1. Review and evaluate medical records to determine if they:
 - a. Properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken.
 - b. Are sufficiently complete at all times to facilitate continuity of care and communication between all those providing patient care services in the Hospital.
 - c. Are adequate, in form and content, to permit patient care monitoring and other quality maintenance activities to be performed.
 - d. Are, when necessary, adequate as medicolegal documents.
 - e. Medical History of the Patient: This should include the chief complaint; details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status; relevant past, social and family history; and inventory by body systems. Whenever possible, the medical history should be obtained from the patient. In programs for children and adolescents, an evaluation of developmental age factors and consideration of education needs should be included, as appropriate. Opinions of the interviewer should not ordinarily be recorded in the

body of the history. The medical history shall be completed within the first twenty-four (24) hours of admission to inpatient services. If an adequate history has been obtained within thirty (30) days prior to admission or procedure, such as in the office of a physician Medical Staff member, or when appropriate, a qualified oral surgeon Medical Staff member, or a duly-licensed physician non-Medical Staff member or physician assistant, a durable, legible copy of this report may be used in the patient's Hospital medical record, provided there has been no subsequent change or changes have been recorded at the time of admission. Obstetrical records should include all prenatal information. A durable legible original or reproduction of the office or clinic prenatal record is acceptable.

- f. **Report of Physical Examination:** This report shall reflect a comprehensive current physical assessment. The physical assessment shall be completed within the first twenty-four (24) hours of admission to inpatient services. If an adequate physical examination has been performed within thirty (30) days prior to admission or procedure, such as in the office of a physician Medical Staff member, or, when appropriate, a qualified oral surgeon Medical Staff member, or a duly-licensed physician non-Medical Staff member, or physician assistant, a durable, legible copy of this report may be used in the patient's Hospital medical record, provided there has been no change subsequent to the original examination or the changes have been recorded at the time of admission. The recorded physical examination must be authenticated by a physician, or when appropriate, by a qualified oral surgeon member of the Medical Staff. The medical record shall document a current, thorough physical examination prior to the performance of surgery.
 - g. A statement of the conclusions or impressions drawn from the admission History and Physical Examination and a statement of the course of action planned for the patient while in the Hospital recorded within twenty-four (24) hours of admission.
2. An admission History and Physical Examination shall be completed in twenty-four (24) hours of admission. In the interim, if the History and Physical Examination has been dictated, a brief note must be on the medical record. If an adequate history has been recorded and a physical examination performed prior to the patient's admission to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of admission History and report of the Physical Examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

3. When the History and Physical Examination is not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be delayed until completed.
 4. Review staff policies, Hospital policies and rules and regulations relating to medical records, including medical record completion, forms, formats, filing, indexing, storage, destruction and availability and recommend methods of enforcement thereof and changes therein.
 5. Act upon recommendations from the Medical Staff Executive Committee, the departments and other committees responsible for patient care monitoring and other quality maintenance and monitoring functions.
 6. Provide liaison with Hospital Administration and Medical Record professionals in the employ of the Hospital on matters relating to medical record practice.
 7. Maintain a permanent record of all actions taken and submit periodic reports and recommendations to the Medical Staff Executive Committee and Chief Executive Officer concerning medical record practices in the Hospital.
- c. Meetings: The committee shall meet a minimum of three times a year.

Section 9. Medical Education/Library Committee

- a. Composition: The committee shall consist of at least two members of the Medical Staff, a representative of Nursing Services, a representative of Administration and representative of other professional departments as deemed appropriate.
- b. Duties: The duties of the committee shall be to:
 - 1) Review and establish policies of the Hospital library.
 - 2) Establish and recommend priorities for library acquisitions.
 - 3) Plan physician continuing medical education.
- c. Meetings: The committee shall meet a minimum of twice a year.

Section 10. Radiation Safety Committee

- a. Composition: The committee shall consist of at least two physicians and other professionals as required by the Nuclear Regulatory Commission. The Chairman of the committee shall be the Hospital's Chief Radiation Officer.
- b. Duties: The duties of the committee shall be to:

1. Insure conformance of the Hospital with the various agencies regulating use of radionuclides.
 2. Review all proposals for diagnostic and therapeutic uses of unsealed radionuclides.
 3. Recommend to the Medical Staff those practitioners having suitable training and experience to perform nuclear medicine procedures.
 4. Develop regulations for the use, transport, storage, and disposal of radioactive materials used in nuclear medicine procedures.
 5. Recommend rules to guide nurses and other individuals who are in contact with patients receiving therapeutic amounts of unsealed radionuclides; rules relating to the discharge of such patients; and rules to protect personnel involved when such patients undergo surgical procedures or autopsy.
- c. Meetings: The committee shall meet quarterly.

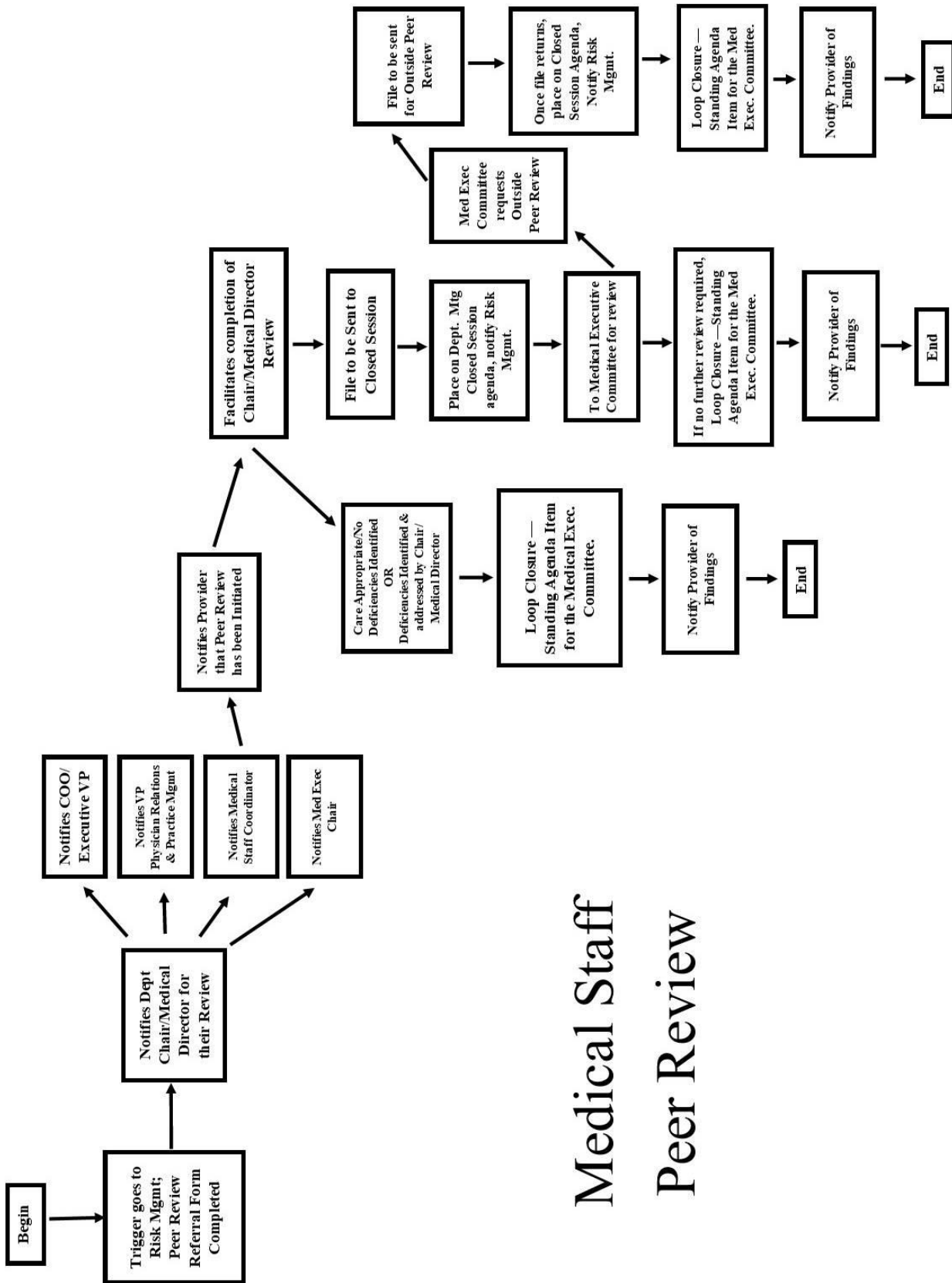
Section 11. Critical Care/Cath Lab Committee

- a. Compositions: The committee shall be comprised of representatives of the Medicine Department, Surgery Department, and Family Practice Department of the Medical Staff, the Nursing Director of the Critical Care Unit, and allied health or other health care professionals providing care to patients in the unit who may participate as non-voting members. The chairperson shall be Director of the Unit.
- b. The Critical Care/Cath Lab Committee Chairperson:
 1. Qualifications:
 - a. Member of the Active Medical Staff.
 - b. Possess the knowledge and skills necessary to admit and manage patients on the unit.
 2. Duties:
 - a. Oversee the committee during meetings and ensure compliance with committee duties.
 - b. Have access to information about the privileges, permitted scope of practice, and/or competence of all persons who admit or treat patients or provide patient care services in the unit. Settle any disputes when questions arise as to the credentialing of anyone for treatment procedures.

- c. Responsible for consulting with the attending physician for making decisions for the disposition of the patient when patient load exceeds optimal operational capacity.
- c. Duties: The duties of the committee shall be to:
 - 1. Establish written criteria for admission to, and discharge from, the unit. Criteria are objective and based on defined physiologic parameters.
 - 2. Review credentials for physicians requesting CCU and Cath Lab privileges.
 - 3. Formulate policies regarding the operation of the unit and to review the policies at least once every three years or as needed.
 - 4. Perform peer review activities for the unit in accordance with continuous quality improvement.
- d. Meetings: The Committee shall meet a minimum of two times a year.

Section 12. Peer Review Committee

- a. The Peer Review Committee shall be a subcommittee of the Executive Committee and shall be comprised of all members of the Executive Committee, or their designee, and the Director of Quality/Risk Management.
- b. Duties: The duties of the Peer Review Committee shall include, but not be limited to:
 - 1. Conduct peer review investigations on cases that are referred from the Peer Review Subcommittee (Hospital Multidisciplinary Team) or other Medical Staff Committees.
 - 2. Send a letter notifying the physician of the concerns of the Peer Review Committee with a copy to the physician's file; request that the physician undertake adequate continuing education with a specified time limit and with guidance for a specified number of hours.
 - 3. These documents will be maintained as a confidential professional/peer review and/or quality assurance document.
- c. Meetings: The Peer Review Committee shall meet as often as necessary and shall maintain a record of its proceedings and actions.
- d. Quorum: The presence of fifty percent (50%) of the members constitutes a quorum.



Medical Staff Peer Review

XIII: MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

- a. Staff meetings shall be held quarterly.
- b. The Staff Meeting held prior to July 1st should be the Staff Meeting at which any election of officers for the ensuing period shall be announced.
- c. The Medical Staff year shall begin on the first Tuesday of July of each calendar year.
- d. Recommendations for appointment to various committees of the Medical Staff shall be made at the meeting prior to July 1st. These committees would then begin functioning on the first Tuesday of July.
- e. Quarterly Staff Meetings
 1. Members of the Medical Staff shall be notified by letter no later than fourteen (14) days prior to the date of the quarterly staff meeting.
 2. The Departmental Chairmen and Committee Chairmen shall report on the activities of the Medical Staff Departments and Committees during the staff year.

Section 2. Special Meetings

- a. The President of the Medical Staff, the Medical Staff Executive Committee, or not less than one-fourth (1/4) of the members of the Active Medical Staff at any time may file a written request with the Medical Staff Executive Committee that a special meeting of the Medical Staff be called. The Medical Staff Executive Committee shall designate the time and place of any such special meeting and it must be within seven (7) days of the date a request was received by the Medical Staff Executive Committee.
- b. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the General Medical Staff not less than two nor more than seven (7) days before the date of such meeting, by or at the direction of the President (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each Staff member at his/her address as it appears on the records of the Hospital. An alternative mode of notification would be telephone notification to the physician personally. A record should be kept of those who could be contacted and those who could not. If seventy-five (75) percent or more can be contacted and agree to a meeting in less than forty-eight (48) hours, such special meeting may be held. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of

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

- c. The Governing Board can call a special meeting in the time intervals implied above and with the methods explained above.

Section 3. Quorum

- a. A quorum is not necessary to make a meeting official. However, Bylaws cannot be changed unless there is an affirmative vote by at least 25% of the eligible voting membership.
- b. A simple majority of those members present is necessary to effect approval of a proposal at any meeting unless otherwise stated in these Bylaws, Rules and Regulations.

Section 4. Attendance Requirements

- a. Each member of the Active Medical Staff shall be required to attend at least fifty percent (50) of all his/her own departmental meetings and General Staff meetings in each fiscal year.
 - 1. If the practitioner has not attended fifty percent (50%) of his/her departmental meetings or General Staff meetings in the past twelve (12) months, he/she automatically loses all voting privileges. This practitioner is automatically on probation with reference to his/her membership on the Medical Staff.
 - 2. A practitioner cannot regain his/her voting privileges until 50% of the departmental meetings or General Staff meetings are attended during the next six months. Reinstatement of voting privileges then becomes automatic.
 - 3. A practitioner can remove his/her name from the Probationary Membership List by attending 50% of the departmental meetings or General Staff during the next six months. If these meetings are not attended, he/she automatically loses all Hospital privileges and must apply for Medical Staff membership if such status is desired.
 - 4. The Executive Committee will consider written requests for excused absences due to extended illness.
- b. The attendance record is kept by the Medical Staff Secretary and is the official source of judging attendance records.
- c. All Medical Staff meetings, including General, Special Committee and Departmental meetings, shall be open to all members of all categories of the Medical Staff.

Section 5. Agenda

- a. The Agenda at each regular Medical Staff meeting shall be:
 - 1. Call to Order.
 - 2. Reports of the Medical Staff Executive Committee and the chairman of the various departments and the General Medical Staff standing committees and the special committees when appropriate.
 - 3. Discussion and recommendations for improvement of professional work in the Hospital.
 - 4. Unfinished Business.
 - 5. New Business.
 - 6. Adjournment.
- b. The Agenda of the Special Meetings shall be:
 - 1. Reading of the Notice calling the meeting.
 - 2. Transaction of business for which the meeting was called.
 - 3. Adjournment.

Section 6. Special Attendance Requirements

In any situation where a practitioner's attendance is considered mandatory by the department chairman or the Medical Staff Executive Committee, such as when a deviation from standard medical practice is involved, the practitioner must attend the meeting unless excused by the Medical Staff Executive Committee for good cause. Such failure shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Staff 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. Notice that attendance is mandatory must be given to the practitioner by Certified Mail at least seven (7) days before the scheduled meeting. The notice should state the reasons for the attendance and should state the subject matter of the meeting as it applies to the involved practitioner. If a practitioner makes a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the President of the Medical Staff or by the Medical Staff Executive Committee, if the President is the practitioner involved, until not later than the next meeting, otherwise the pertinent clinical information will be presented and discussed as scheduled.

XIV: CONFIDENTIALITY, IMMUNITY AND RELEASES

Section 1. Authorization and Conditions

By applying for or exercising clinical privileges or providing specified patient care services within the Hospital, a practitioner:

- a. Authorizes representatives of the Medical Staff and the Hospital to solicit, provide and act on information bearing on his/her professional ability and qualifications, as regards patient care.
- b. Agrees to be bound by the provisions of Article V, Section 1(e) and any other restrictions, limitations, and conditions with respect to his/her application for or acceptance of Medical Staff membership and the continuation of such membership or his/her exercise of clinical privileges or provision of specified patient services at this Hospital.

Section 2. Immunity from Liability

- a. No representative of the Medical Staff or the Hospital shall be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as a representative, if the representative acts in good faith and without malice.
- b. No representative of the Medical Staff or the Hospital and no third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Medical Staff or Hospital or to any other health care facility or organization of health professionals concerning a practitioner who is or has been an applicant to or a member of the Medical Staff or did or does exercise clinical privileges or provides specified services at the Hospital provided that such representative or third party acts in good faith and without malice.

Section 3. Confidentiality

- a. The confidentiality and immunity provided by this Article XIV shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with the Hospital's or any other health care facility's or organization's activities including but not limited to:
 1. Application for appointment, clinical privileges or specified services.
 2. Periodic reappraisals for appointment, clinical privileges or specified services.
 3. Corrective action and summary suspension.

4. Hearings and appellate review.
 5. Medical care evaluation activities.
 6. Utilization review activities.
 7. Other Hospital, clinical section or committee activities.
- b. The information referred to in this Article XIV may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that may directly or indirectly effect patient care.

Section 4. Release

Each practitioner shall upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in Article XIV, Section 3. Execution of such release shall not be deemed a prerequisite to the effectiveness of this Article XIV.

XV: RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice by a majority vote of the total membership of the Active eligible Medical Staff. Such changes shall become effective when approved by the Governing Board.

XVI: AMENDMENTS TO BYLAWS

Amendments to the Bylaws can be accomplished by either Plan A or Plan B.

Plan A:

1. A practitioner can submit a proposed amendment at any General Medical Staff meeting or at a Special Medical Staff meeting called for the purpose of consideration of that amendment.
2. The General Medical Staff or Special General Medical Staff meeting will then vote to accept or reject the amendment. If the amendment is accepted, it will be referred to the Bylaws Committee for its consideration.
3. The Bylaws Committee will consider the amendment and return the amendment at the next General Medical Staff meeting or at the next special General Medical Staff meeting called for consideration of that particular amendment, at which time the General Medical Staff will again vote on the amendment. At that meeting, the amendment will be accepted or rejected. If there have been alterations by the Bylaws Committee between the first and second General Medical Staff meetings, such alterations will not require a third meeting of the General Medical Staff for ratification. The acceptance at the second General Medical Staff meeting will be considered to be adequate.
4. To pass an amendment at the first General Medical Staff meeting or to ratify it at the second General Medical Staff meeting requires an affirmative vote by at least twenty-five percent (25%) of the total eligible Staff members. Eligible Medical Staff members are all Active Medical Staff members.
5. At least twenty-four (24) hours must elapse between the first and second General Medical Staff meetings which result in a final action on an amendment to the Bylaws.
6. In lieu of approval at a second or special staff meeting, a mail ballot, with the same safeguards as voting for officers, sent to each eligible voting staff member shall be acceptable for ratification of the amendment provided that at least fifty percent (50%) of the ballots are returned.

Plan B:

1. The Bylaws Committee submits an amendment for consideration by the General Medical Staff.
2. The General Medical Staff accepts or rejects the amendment.
3. If the amendment is accepted, it must be passed at a second General or Special

Medical Staff meeting (held for that purpose) before final ratification is effected.

4. In lieu of approval at a second or special staff meeting, a mail ballot sent to each eligible voting staff member shall be acceptable for ratification of the amendment provided that at least fifty percent (50%) of the ballots are returned.

XVII: ADOPTION

The Bylaws together with the appended rules and regulations shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws and Rules and Regulations and shall become effective when approved by the Governing Board of the Hospital.

Adopted by the Medical Staff on _____.

President, Medical Staff
MercyOne Clinton Medical Center

Secretary, Medical Staff
MercyOne Clinton Medical Center

Adopted by the Governing Board on _____.

Secretary, Governing Board
MercyOne Clinton Medical Center

A. Rules and Regulations

The Medical Staff shall adopt such Rules and Regulations as may be necessary for proper conduct of its work. Such Rules and Regulations shall be a part of these Bylaws except that they may be amended at any regular meeting at which a quorum is present without previous notice by a majority vote of the total membership of the Active Medical Staff. Such amendments shall become effective when approved by the Directors.

B. Policy/Procedures

Any Medical Staff Policy initiated by the Medical Executive Committee and approved by the Board shall be communicated by the Medical Executive Committee to the Medical Staff via regular channels of communication before enacted.

C. Roberts Rules of Order

Rules contained in Roberts Rules of Order shall govern the Medical Staff in all cases in which they are not inconsistent with the Bylaws or with special rules of order of this Medical Staff.

D. Admission and Discharge of Patients

1. A patient may be admitted to the Hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.
2. The ER physician has privileges to write temporary admitting orders. Upon admission to the receiving unit, full responsibility for the patient's care is assumed by the attending physician. The ER physician will not write temporary admitting orders without the approval and knowledge of the attending physician.
3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for the transmitting of reports of the condition of the patients to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff Member, a note covering the transfer of responsibility shall be entered on the Order Sheet in the medical record.
4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
5. Practitioners admitting emergency cases shall be prepared to justify to the Medical Staff Executive Committee and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The History and Physical Examination must clearly justify the patient being admitted on an emergency basis

and these findings must be recorded on the patient's chart as soon as possible after admission.

6. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable service willing to attend him/her. Where no such selection is/can be made, a member of the Active Medical staff on duty in the Service will be assigned to the patient, on a rotation basis, by the method developed by the Emergency Services Committee.
7. Each member of the Medical Staff who does not reside in the immediate vicinity shall name an appropriate member of the Active Medical Staff who is a resident in the area who may be called to attend his/her patients in an emergency, or until he/she arrives. In case of failure to name such associate, the Chief Executive Officer, President of the Medical Staff, or Chief of Service concerned, shall have authority to call any member of the Active Medical Staff in such an event. **Call coverage** arrangements shall be approved by the Credentials Committee with recommendations from the department of which the physician is a member through the normal credentialing process.
8. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement thereof. These shall be developed by each clinical department and approved by the Medical Staff Executive Committee.
9. The Chief Admitting Clerk will admit patients on the basis of the following order of priorities:
 - a. Emergency Admission

Within forty-eight (48) hours following an emergency admission, the attending practitioner can be required to furnish the Medical Staff Executive Committee a signed sufficiently complete documentation of need for this admission. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the General Medical Staff for appropriate action.
 - b. Urgent Admission

This category includes those so designated by the attending practitioner and shall be reviewed as necessary by the President of the Medical Staff to determine priority when all such admissions for a specific day are not possible.
 - c. Preoperative Admission

This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the President of the Medical Staff may decide the urgency of any specific admission.

- d. Routine Admission
This will include elective admissions involving all services.
10. Areas of restricted bed utilization and assignment of patients shall be as follows:
- Surgery, Obstetrics, Pediatrics and the Intensive Care Unit. Patients may be admitted without regard to the above restrictions only after consultation with the Department Chairman, or his/her designee, of the geographic area to which the patient is to be admitted. It is understood that when deviations are made from assigned areas as indicated above, the admitting clerk will correct these assignments at the earliest possible moment, in keeping with transfer priorities.
11. Patient Transfers
- a. Emergency Room to Acute Care patient bed.
 - b. From Obstetric patient care area (unit) to General Care area (unit) when medically indicated.
 - c. From Intensive Care Unit to Post Coronary Care or General Medical Care (unit).
- No patient will be transferred without such transfer being approved by the responsible practitioner.
12. 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/her patient might be a source of danger from any cause whatsoever.
13. For the protection of patients, the Medical and Nursing Staff and the Hospital, precautions to be taken in the care of the potentially suicidal patient include:
- a. Any patient known or suspected to be suicidal in intent shall be admitted to a room specifically prepared for such a problem (if such room is available) and must be in the company of an observer (a reliable member of the family is adequate) twenty-four (24) hours a day. If there are not accommodations available in this area, the patient shall be referred, if possible, to another institution where suitable facilities are available.
 - b. When transfer is not possible, the patient may be admitted to a general area of the Hospital, and as a temporary measure, bars or locks may be placed on the windows of the patient's room and special nursing companionship provided. Such patients should spend the daytime hours in the area where special observation and therapy are available.
14. Admission to Intensive and Cardiac Care Units.

If any question as to the validity of admission to or discharge from the Intensive Care Unit should arise, that decision is to be made through consultation with the Chairman of the Intensive Care Committee or the Chairman of the Department of Medicine.

15. Patients shall be discharged only on a written order of attending practitioner. 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.

E. Medical Records

1. The parts of the medical record that are the responsibility of the medical practitioner are authenticated by him/her.
2. Members of the Medical Staff, or their designee, shall be required to visit hospitalized patients on a timely basis. 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 pertinent clinical problems should be clearly identified as in the progress notes and correlated with specific orders as well as results of tests and treatment. It is recommended that progress notes be created on a timely basis. Noncompliance may result in loss of admitting privileges. This will be monitored by the Medical Records Committee.
3. All patients will have a brief post-procedure handwritten note, post-procedure PowerNote or completed post-procedure form before the surgeon or proceduralist leaves the patient. Post-op/procedure notes must contain all elements as required by The Joint Commission.
4. Operative (procedure) reports dictated or written immediately after surgery shall include a detailed account of the findings at surgery as well as details of surgical techniques, specimens removed, post-operative diagnosis, and the name of the primary surgeon and assistants.

Operative reports should be submitted immediately after surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made part of the patient's current medical records. The physician will be notified within 48 hours of the procedure that the operative report has not been dictated/created. The physician will be given an additional 24 hours to dictate/create the operative report. Failure for the operative report to appear on the chart in seventy-two (72) hours due to the practitioner's failure to dictate or record such operative reports shall cause suspension of the practitioner's scheduling of elective procedures until such time that the operative reports are brought into compliance.

5. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, 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.

6. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital within twenty-four (24) hours after admission.
7. Entries in medical records are made only by individuals given this right as specified in Hospital and Medical Staff policies. All entries in the record, including all orders, are dated, timed, and authenticated, and a method is established to identify the authors of entries. Identification may include written signatures, initials, or computer key.
8. Final diagnosis shall be recorded in full and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.
9. A discharge summary (clinical resume) shall be created or dictated on all medical records of patients Hospitalized over forty-eight (48) hours except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Medical Staff Executive Committee and for these, a final summation-type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.
10. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
11. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner or by another practitioner.
12. Free access to all medical records of all 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 Chief Executive Officer, 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 the Hospital.

13. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Executive Committee of the Medical Staff.
14. The patient's medical record shall be complete at time for discharge, including progress notes, final diagnosis, and dictated/created discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available electronically or in Health Information Management.
15. Incomplete Records and Admitting Privileges.

Preamble: The timely completion of medical records is an integral part of quality medical care. If a medical practitioner's medical records are endangering accreditation with The Joint Commission or quality of care, the Health Information Management office should refer the matter to the Medical Records Committee. The committee will judge the matter and decide whether to refer it to the Executive Committee. The Executive Committee shall make a decision as to continuation or suspension of privileges and treatment of patients not already under treatment by the involved physician. The present appeals process in the Bylaws remains in effect. In cases where emergency care is needed from the physician whose privileges are in suspense, that can be given according to language already in the Bylaws.

- a. If a practitioner has one or more record(s) which have been incomplete for seven (7) days due to the practitioner's failure to dictate, create, and/or authenticate the patient records, the Medical Record Administrator shall notify the affected practitioner by telephone to him/her or to his/her secretary or nurse that he/she has fourteen (14) additional days to complete these records.
- b. If the practitioner has not brought the delinquent records to completion due to the practitioner's failure to dictate, create, and/or authenticate the patient records within the fourteen (14) additional days, (i.e. total of 21 days), the Medical Record Administrator shall notify the Chief Executive Officer or designee who will then also notify the Chief of the Medical Staff. If illness or absence from the office or other valid reasons have not interfered, the practitioner's privileges will be suspended for admissions and elective procedures until the records are complete. Notification of suspension will be sent to the provider by Certified Mail.
- i. Appeal Process

If a practitioner believes he/she has valid reasons for the delay, he/she may appeal the suspension by notifying the Medical Record Committee Chair in writing of the reasons and the intended acceptable timeline for completion of the record.

16. The medical record is the property of the Hospital and is maintained for the benefit of the patient, the physician and the Hospital. It is the responsibility of the Hospital to safeguard the information on the record against loss, tampering or use by unauthorized persons.
17. Pre-anesthesia and Post-anesthesia Notes
 - a. The pre-anesthetic note must be present on the chart prior to the inception of anesthesia in all but the most emergency circumstances. Failure of these notes to be on the chart will result in the delay of the procedure until completed.
 - b. The post-anesthesia visit note must be dictated or recorded by the physician within twenty-four (24) hours after the completion of anesthesia. Failure of the physician to dictate or record these notes within forty-eight (48) hours after completion of anesthesia will result in loss of anesthesia privileges until such time as the notes are included in the chart.

F. General Conduct of Care

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The Admitting Officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.
2. All orders for treatment shall be in writing. A **verbal order** shall be considered written if dictated to a duly authorized person (Registered Nurse, Licensed Physical Therapist, Licensed Occupational Therapist, Licensed Speech Pathologist, Certified Respiratory Therapist, and Registered Respiratory Therapist, Pharmacist, Radiology Technologist, Registered Dietician and Medical Laboratory Assistant) functioning within his/her sphere of competence and signed by the responsible practitioner. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner per his/her own name. The responsible medical practitioner shall authenticate all verbal orders in compliance with State regulations. If the patient is discharged, the verbal order shall be authenticated following the guidelines set forth in Section D, Medical Records, of the Bylaws, Rules and Regulations.
3. The practitioner'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. All previous orders are canceled when patients go to surgery.
5. All drugs and medications administered to patients shall be those listed in the latest

edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

6. Any qualified practitioner with clinical privileges shall be called for **consultation** within his/her area of expertise.
7. Except in emergency, **consultation** is recommended in the following situations:
 - a. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/She will provide written authorization to permit another attending practitioner to attend or examine his/her patient, except in an emergency. It is the responsibility of the requesting physician to personally contact the consulting physician if it is urgent.
 - b. If a nurse 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, he/she shall call this to the attention of his/her superior who in turn may refer the matter to the Vice President of Patient Care Services or Administrator on Call. The initiating nurse shall not be entitled to anonymity. A nurse who is acting upon instruction of a committee who has a practitioner under surveillance is granted anonymity in reporting information to that committee. If warranted, Administration may bring the matter to the Department Chairman or to the President of the Medical Staff wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Department Chairman may himself/herself request a consultation.
8. Relationship of Consultants and Attending Physicians, Patients, Nurses and Chief Executive Officer in Problem Situations.
 - a. An attending physician who desires only a consultation shall request a consultation per se. He/She is then free to accept or reject the recommendations of the consultant or refer the patient to the consultant for care.
 - b. A consultant is free to accept or reject a requested consultation except where he/she is directed by the president of the Medical Staff to act as a consultant.
 - c. If a consultant feels that the welfare of the patient is in significant jeopardy because of the unwillingness of the attending physician to accept good advice or refer a patient, he/she may refer this matter to the Chief of the Service or the President of the Medical Staff or their delegates.
 - d. The attending physician will be contacted by the Department Chairman or the

President of the Medical Staff and advised of the problem.

- e. If the attending physician still refuses to refer or follow good advice and if the President of the Medical Staff or the Department Chairman and/or his/her designee think that referral or change of therapy is indicated, the President of the Medical Staff or the Chief of the Service can dismiss the physician from the case immediately according to these Bylaws and assign the patient to a practitioner who is qualified to handle the case and who is satisfactory to the patient or the person responsible for making the patient's decisions.

The dismissed practitioner then has recourse to the hearing and appeals mechanism stated in the Bylaws.

- f. If the Chief Executive Officer is advised by the Director of Nursing Services or the Director's delegate of concern over the adequacy of care of a patient by a practitioner, the Chief Executive Officer can refer the matter to the President of the Medical Staff or the Department Chairman who will contact the physician involved and decide whether consultation or referral is indicated.

- 1. If the physician refuses to refer or accept consultation and good advice, the mechanism in 8 e can be affected.

- 2. If consultation is refused and is judged to be indicated by the President of the Staff or the Department Chairman, the latter can order a consultation or referral and pick the consultant or referral physician subject to consultation and consent of the patient.

- g. If a patient desires consultation or referral, he/she should request this of the attending practitioner and if the attending physician refuses the patient, the Director of Nursing Services can refer the matter to the chief executive Officer, who will consult with the Department Chairman or the President of the Medical Staff who will act accordingly to the paragraphs immediately preceding this statement.

- h. In extraordinary cases where the health of the patient or the welfare of the Hospital are seriously jeopardized, the Chief Executive Officer can order consultations and/or referral of a patient. Normally, the consultant will be the Chairman of the Department or his designated replacement. It is understood that this would be a rare event and would presuppose malfunctioning of the mechanism already delineated under General Conduct of Care Item 8. All such consultations or referrals must be with the consent of the patient or person qualified to make decisions for the patient if the patient is unable to do so. If the patient or his/ her representative refuse consultation or referral, a release from responsibility should be submitted and signed by the patient or his/her representative.

9. Private patients should be attended by their own private physicians. Patients applying for admission who have no attending physician will be offered the care of physicians who allow their names or group's name to be available for such purpose. If a physician cannot be obtained to care for a patient, it is the duty of the Department Chairman to assign a physician to care for the patient. The Department Chairman can volunteer to care for the patient.
10. Standing orders must be approved by the appropriate department and reviewed annually. These orders should be signed by the attending physician.

G. General Rules Regarding Surgical Care

1. Except in emergencies, the history, physical and preoperative diagnosis and pertinent laboratory tests must be recorded on the patient's medical record prior to any inpatient or outpatient surgical procedure permitted in the operating suite. If not recorded, the operation shall be delayed until completed. In any emergency, if possible, the practitioner shall make at least a note regarding the patient's condition and reason for surgery prior to induction of anesthesia and start of surgery.
2. A patient admitted for dental care or podiatric care is a dual responsibility involving the dentist or podiatrist and physician member of the Medical Staff.
 - a. Dentist's responsibilities:
 1. A detailed dental history justifying Hospital admission.
 2. A detailed description of the examination of the oral cavity and preoperative diagnosis.
 3. A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the Hospital pathologist for examination.
 4. Progress notes as pertinent to the oral condition.
 5. Clinical resume (or summary statement).
 - b. Podiatrist's Responsibilities:
 1. A detailed podiatric history and indications of the patient's general health status.
 2. Description of examination of the feet or ankle and a pre-operative diagnosis with a plan of care.

3. A complete operative report.
 4. Sending of tissue to the hospital pathology service for examination.
 5. Progress notes pertinent to the podiatric condition.
 6. A clinical resume (or summary statement).
- c. Physician's responsibilities:
1. Medical history pertinent to the patient's general health.
 2. A physical examination to determine the patient's condition prior to anesthesia and surgery.
 3. Supervision of the patient's condition prior to anesthesia and surgery. A member of the Active Medical Staff must be present during all operative procedures requiring general anesthesia.
 4. Supervision of the patient's general health status while hospitalized.
- d. The discharge of the patient shall be on written order of the dentist or podiatrist member of the Medical Staff.
- e. An oral surgeon or podiatrist who admits a patient without medical problems may complete an admission history and a physical examination and assess the medical risks of the procedure to the patient if qualified to do so. Criteria to be used in identifying such a qualified oral surgeon or podiatrist shall include, but need not be limited to the following: successful completion of a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education, or successful completion of an approved podiatric two-year surgical residency program or additional fellowship training; and, as determined by the Medical Staff, evidence that the oral surgeon or podiatrist who admitted the patient is currently competent to conduct a complete history and physical examination to determine the patient's ability to undergo the surgical procedure the oral surgeon or podiatrist proposes to perform. All patients must have a backup physician designated by the call surgeon, with the back-up physician's permission, who would respond in case of an untoward incident requiring medical care above and beyond what the oral surgeon is qualified to perform. Such backup physician would need to be in sufficient proximity to the operating facilities so that emergency care required by such untoward incident would be available in an appropriate time.
- f. Patients with medical problems admitted to the Hospital by qualified oral surgeons or podiatrists, and patients admitted for dental care or podiatric care by individuals who are not qualified oral surgeons or podiatrists, shall receive the

same basic medical appraisal as patients admitted for other services. This includes having a physician who either is a member of the Medical Staff or is approved by the Medical Staff to perform an admission history, a physical examination, an evaluation of the overall medical risk and record the findings in the medical record. The responsible dentist shall take into account the recommendations of this consultation in the overall assessment of the specific procedure proposed and the affect of the procedure on the patient. When significant medical abnormality is present, the final decision must be a joint responsibility of the dentist or podiatrist and the medical consultant. The dentist or podiatrist should be responsible for that part of the history and physician examination related to dentistry. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present on admission or that may arise during Hospitalization of dental or podiatric patients.

3. The Anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation, operative record of monitoring, and post-anesthesia follow-up of the patient's condition.
4. All operations performed shall be fully described by the operating surgeon and made a part of the patient's permanent records.
5. Surgical Assistants

In general, the decision on whether to have an M.D. assistant is left up to the attending physician. A physician may request a non-M.D. assistant or no assistant for specific procedures. These procedures must be listed and submitted through the credentialing procedure. Non-M.D.'s must make a formal application for appointment to the Hospital as specified in Section K, Ancillary Health Professionals, paragraph 2.

6. Specimens removed at the operation shall be sent to the Medical Staff member pathologist of the surgeon's choice, who shall make such examination as he/she may consider necessary to arrive at a diagnosis. His/her authenticated report shall be made a part of the patient's medical record.
 - a. Exceptions to sending specimens removed during a surgical procedure to the laboratory may be made only when quality of care has not been compromised or when another suitable means of identification is routinely used and when an authenticated report is made to document the removal of the specimen.
 - b. The exceptions to sending specimens removed during a surgical procedure to the laboratory will be decided by the appropriate staff department in consultation with the pathologist, and the exceptions must be decided upon before the fact (i.e., before the given surgical procedure is done).

7. Surgical Privileges (see special section entitled "Delineation of Privileges").
8. Following surgery and prior to dismissal, patients having general or spinal anesthesia must be seen by a physician. The presence or absence of anesthesia-related complications should be documented in the Progress Notes or Discharge Summary.

H. General Rules Regarding Obstetrical Care

1. Prenatal history and physical examinations are required on all obstetrical patients. A copy done by the physician in the office and signed by him/her may be substituted for one done in the Hospital.
2. Patients requiring Cesarean section should have a reasonably complete history and physical examination performed before surgery. This should also be recorded before surgery unless a delay would result in risk to the patient.
3. If unable to locate a patient's physician or his/her substitute where the urgency of the situation dictates, the nurse in charge of the obstetrical case may call upon any member of the Medical Staff for physician care.
4. All patients presenting to OB Triage require a medical screening examination under the Emergency Medical Treatment and Labor Act (EMTALA) to determine whether a medical emergency exists. For pregnant women, the process requires assessment of both the mother and the fetus. Labor nurses can perform medical screening examinations, but must discuss the medical examination findings with the primary care provider to determine the plan of care.

I. Emergency Services

1. The Medical Staff shall adopt a method of providing medical coverage in the Emergency Services area. This shall be in accord with the Hospital's basic plan for the delivery of such services including the delineation of clinical privileges for all physicians who render emergency care.
2. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:
 - a. Adequate patient identification.
 - b. Information concerning the time of the patient's arrival, means of arrival and by whom transported.
 - c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the Hospital.

- d. Description of significant clinical, laboratory and roentgenologic findings.
 - e. Diagnosis.
 - f. Treatment given.
 - g. Condition of the patient on discharge or transfer.
 - h. Final disposition, including instructions given to the patient and/or family, relative to necessary follow-up care.
3. Each patient's medical record shall be signed by the practitioner in attendance.
 4. There shall be a monthly review of Emergency Room medical records by the Emergency Room Committee to evaluate quality of emergency medical care. Reports shall be submitted to the Medical Staff Executive Committee.
 5. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a committee which includes at least one member of the Medical Staff, the Director of Nursing Services or his/her designee and a representative from administration. When approved by the Medical Staff and Governing Board, the plan shall be appended to this document.
 6. The Disaster Plan should make provisions within the Hospital for:
 - a. Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.
 - b. An efficient system of notifying and assigning personnel.
 - c. Unified medical command under the direction of a designated physician (the Chairman of the Emergency Services Committee or designated substitutes).
 - d. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
 - e. Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care.
 - f. A special disaster medical record, such as an appropriately-designed tag, that accompanies the casualty as he/she is moved.
 - g. Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy.

- h. Maintaining security in order to keep relatives and curious persons out of the triage area.
 - i. Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communication media will help to provide organized dissemination of information.
 - j. The plan shall be coordinated with the Disaster Plan of MercyOne Clinton Medical Center.
 - k. Evacuation of patients from one section of the Hospital to another section or evacuation from Hospital premises.
7. All physicians shall be assigned to posts (either in the Hospital or in the auxiliary Hospital, or in mobile casualty stations) and it is their responsibility to report to their assigned stations.

The President of the Medical Staff, the Chairman of the Emergency Services Committee, and the Chief Executive Officer should work as a team to coordinate activities and directions.

- 8. The Disaster Plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as Administrative, Nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all shall be made.
- 9. All policies concerning patient care will be the joint responsibility of the Chief of the Emergency Services Committee, the President of the Medical Staff and the Chief Executive Officer.
- 10. In an acute disaster situation, all physicians on the Medical Staff specifically agree to relinquish direction of the professional care of their patients to the Chairman of the Emergency Services Committee and the President of the Medical Staff and whomever these practitioners designate to supervise the Medical Staff during the disaster.

J. Special Care Units

For special care units such as Recovery Room, Intensive Care Units of all kinds, Coronary Care Units, Newborn Nurseries, etc., appropriate committees of the Medical Staff should adopt specific regulations. These regulations should be subject to approval of the Medical Staff Executive Committee and the Governing Board.

K. Autopsies

Every member of the Medical Staff is expected to be actively interested in securing autopsies.

No autopsy shall be performed without proper written consent of those legally responsible for granting such permission. The autopsies should be performed under the direction of the Hospital Pathologist or a physician delegated this responsibility and by the Hospital Pathologist or the President of the General Medical Staff.

Refer to current hospital policy for further information.

L. ADVANCED PRACTICE PROFESSIONALS

Assignment, Supervision and Compliance. Although responsible to the Medical Staff and Board, Advanced Practice Professionals are not Members of the Medical Staff. Each APP may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted to him/her in accordance with these Bylaws, except as otherwise permitted by Sections 5.5 and 5.6. Each APP acts under the overall supervision of an identified Supervising Member approved by the Board, acting on the recommendation of the Medical Executive Committee. The APP shall immediately notify the Chief of Staff in writing if the APP's supervisory arrangement with the Supervising Member ends. An APP may not be granted Clinical Privileges that exceed those of his/her Supervising Member. The Hospital may grant Clinical Privileges that are less extensive than the scope of activities an APP is licensed to perform. APP's shall comply with these Bylaws, the Rules, and any Hospital policy intended to govern their activities.

Qualifications. APP's must possess a license or registration to practice their profession in the state of Iowa, if applicable. Applications for initial, renewed, increased and decreased Clinical Privileges will be processed using the procedures and criteria set forth in Articles IV and V (subject, however, to Due Process in accordance with Article XII, rather than Article XI) to the extent applicable to the Practitioner's profession.

Meeting Attendance APP's may attend meetings of the Medical staff and/or their department at the request of their Supervising Member and subject to the approval of the individual presiding at the meeting. If so permitted to attend the meeting, APP's may not vote, nor may they otherwise participate unless requested by the presiding officer. (Section may be modified to reflect practice.)

Suspension and Termination An APP's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Articles VII through X) in the same manner as a Member of the Medical Staff (subject, however, to Due Process in accordance with Article XII, rather than Article XI), as well as in accordance with the terms of any written contract the APP may have with the Hospital and, in the case of a Hospital-employed APP, in accordance with any applicable Hospital policy. If (a) the Supervising Member ceased to be a member of the Medical Staff, (b) the supervising arrangement (such as collaboration

agreement or employment) between the APP and the Supervising Member terminates, or (c) the APP ceases to be an employee of the Hospital, if applicable, then the APP's Clinical Privileges shall terminate automatically, without Due Process. The events described in (a) and (b) will not result in automatic termination of the APP's Clinical Privileges if the Board (acting on the MEC's recommendation) immediately approves a substitute Supervising Member.

Section M. MERCYONE CLINTON MEDICAL CENTER
Clinton, Iowa

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POLICY AND PROCEDURE MANUAL

LEVEL I	MEDICAL STAFF	POLICY NUMBER
		8720.1001.0

POLICY: DISRUPTIVE BEHAVIOR INVOLVING PRACTITIONERS

ISSUE DATE 7/05

PRESIDENT, MEDICAL STAFF

EFFECTIVE DATE 7/05

PRESIDENT & C.E.O.

REVIEW DATE

CHAIR, BOARD OF DIRECTORS

REVISION DATE

I. PURPOSE:

To promote a professional, safe work environment, which is critical to high quality patient outcomes, and to the recruitment and retention of the best physicians, nurses and other staff.

To define unacceptable disruptive behavior by Medical Staff members and individuals who have been granted clinical privileges at MercyOne Clinton Medical Center (“Practitioners”), and to delineate the response to such behavior.

II. POLICY STATEMENT:

Harassment, discrimination and other disruptive behavior by Practitioners is unacceptable to the Medical Staff and will be corrected and, if appropriate, disciplined.

- A. For the purposes of this Policy, “disruptive behavior” is defined as any conduct or behavior which:
1. Jeopardizes or is inconsistent with quality patient care or with the ability of others to provide quality patient care in a MercyOne Clinton Medical Center facility, including (a) sexual harassment, (b) discrimination or other harassment in violation

of MercyOne Clinton Medical Center's policies or (c) a Practitioner knowingly making a false report of disruptive behavior,

2. Is unethical, and/or
3. Constitutes the physical or verbal abuse of others involved with the provision of patient care at MercyOne Clinton Medical Center or physical or verbal abuse of a MercyOne Clinton Medical Center patient/visitor.

“Sexual harassment” includes unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature where submission to such conduct is made an explicit or implicit condition of employment or future employment-related decisions; or such conduct has the purpose or effect of unreasonably interfering with an individual’s work or creating an intimidating, hostile or offensive work environment.

MercyOne Clinton Medical Center policy also prohibits discrimination and harassment on the basis of race, color, religion, sex, national origin and other bases prohibited by law. Harassment is a form of discrimination and consists of unwelcome conduct that affects an individual’s tangible job benefits, interferes unreasonably with an individual’s work performance, or creates an intimidating, hostile or offensive work environment.

- B. Disruptive behavior occurs in varying degrees, which are classified into 3 levels of severity. Level I behavior is the most severe violation of this policy. Any corrective action will be commensurate with the nature and severity of the disruptive behavior. Repeated instances of disruptive behavior will be considered cumulatively and action taken accordingly.
- C. The Chief of Staff and Department Chairperson will follow these guidelines when classifying severity of conduct:
 1. Level I: Physical violence or other physical abuse, which is directed at person(s). Sexual harassment involving physical contact.
 2. Level II: Verbal abuse (written or oral) such as unwarranted yelling, swearing or cursing; threatening, humiliating, discriminatory, sexual or otherwise inappropriate comments directed at person(s), including verbal retaliation for the filing of a complaint against the Practitioner; or physical violence or abuse directed in anger at an inanimate object.
 3. Level III: Verbal abuse (written or oral), which is directed at large – but has been reasonably perceived by an observer to be disruptive behavior as defined above.
- D. The Medical Staff shall promote continuing awareness of this policy among the Medical Staff and the Hospital community, including the following efforts:
 1. Sponsor or support educational programs on disruptive behavior to be offered to Practitioners and Hospital employees.
 2. Disseminate this Policy to all current Practitioners upon the adoption of the policy and to all new Practitioners upon joining the Staff and/or obtaining

clinical privileges.

3. In appropriate cases, refer a Practitioner who exhibits disruptive behavior to the Executive Committee to obtain education, behavioral modification, or other treatment to prevent further violations, recognizing that such behavior may be a manifestation of mental illness, stress, substance abuse, marital discord, or similar problems.

III. PROCEDURE:

- A. Disruptive behavior by Practitioners may result in corrective action, which shall be carried out according to the Medical Staff Bylaws. This policy shall not prevent an authorized individual from requesting corrective action or imposing summary suspension, in accordance with the Medical Staff Bylaws.
- B. A Practitioner who engages in disruptive behavior may be subject to disciplinary action pursuant to MercyOne Clinton Medical Center's human resources policies, in addition to whatever action is taken under this policy and/or the Medical Staff Bylaws.
- C. Complaints about a practitioner regarding alleged disruptive behavior must be in writing and directed to the Chief of Staff. A written complaint may be submitted by a representative of MercyOne Clinton Medical Center's Human Resources or other appropriate department based on information gathered by that department. MercyOne Clinton Medical Center's Human Resources department will be promptly notified of any complaints (a) filed regarding a Practitioner who is employed by MercyOne Clinton Medical Center or (b) filed by, or involving interaction with MercyOne Clinton Medical Center personnel. The Chief of Staff will immediately, upon receipt, notify MercyOne Clinton Medical Center's President and CEO of all complaints received under this policy and the disposition thereof.
- D. The Chief of Staff, in conjunction with the Executive Committee, will review the complaint immediately, make an initial determination of authenticity and severity level and respond in accordance with the procedures set out below. In all cases the Practitioner involved shall be provided with an **exact copy** of the complaint. If no corrective action is taken a confidential memorandum, summarizing the disposition of the complaint shall be retained in the Practitioner's peer review file. The involved Practitioner may submit a rebuttal to the charge(s) in writing.
- E. Complaints shall be responded to in accordance with the following procedures. If MercyOne Clinton Medical Center personnel will be interviewed, a representative of MercyOne Clinton Medical Center's Human Resources department will participate in the interview. If a patient, patient's representative or visitor will be interviewed, a representative of MercyOne Clinton Medical Center's Quality Risk Department will participate in the interview.

1. Level I: Upon receipt of a Level I complaint, the Chief of Staff in conjunction with the Executive Committee will cause an immediate investigation to be performed. If a Level I complaint is determined to have merit, any of the individuals authorized by the Medical Staff Bylaws to initiate corrective action may do so. Procedures outlined in Article VIII of the MercyOne Clinton Medical Center Medical Staff Bylaws will be followed, including possible summary suspension.

2. Level II: Upon receipt of a Level II complaint, the Chief of Staff (or the appropriate Department Chairperson, at the request of the Chief of Staff) shall interview the party who filed the complaint and, if possible, any witnesses within five (5) working days of receiving the complaint. This investigation will be documented and retained with the complaint. The Department Chairperson or Chief of Staff and another member of the Medical Staff Executive Committee shall interview the Practitioner within five (5) working days. The practitioner will be provided the opportunity to respond in writing. The Chief of Staff, in collaboration with the Department Chairperson, will do one or more of the following:
 - a. Determine that no action is warranted.
 - b. Issue a warning.
 - c. Require the Practitioner to make a written apology to the affected individual(s).
 - d. Refer the Practitioner to the Executive Committee.
 - e. Provide a summary of the findings and conclusions to the Executive Committee; Initiate corrective action pursuant to the Medical Staff Bylaws, if indicated.

3. Level III: Upon receipt of a Level III complaint, the Chief of Staff (or the appropriate Department Chairperson, at the request of the Chief of Staff) shall interview the party who filed the complaint and, if possible, any witnesses within ten (10) days of receiving the complaint. The Practitioner will also be interviewed and will be provided the opportunity to respond in writing. The Chief of Staff will do one or more of the following:
 - a. Determine that no action is warranted.
 - b. Issue a warning.
 - c. Require the Practitioner to make a written apology to the affected individual(s).
 - d. Refer the Practitioner to the Executive Committee.
 - e. Provide a summary of the findings and conclusions to the Executive Committee; Initiate corrective action pursuant to the Medical Staff Bylaws, if indicated.

NOTE: Documentation of interviews and meetings regarding complaints at any Level will be retained in the Practitioner's confidential peer review file. Any action required of the Chief of Staff or Department Chairperson under this Policy may be delegated to another appropriate individual.

Supersedes Policy: None
Distribution to: All Departments

N. Miscellaneous

1. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and Hospital personnel from those who are a source of danger from any cause whatsoever, or to assure the patient from self harm.
2. All laboratory work should be done under the supervision of a pathologist.
3. A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. The statute of the consultant is determined by the General Medical Staff on the basis of an individual's training, experience and competence.
4. Essentials of a Consultation

A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to operation.
5. It is the philosophy of the medical staff to treat all patients with dignity and respect. Therefore, chemical and physical restraints will be used only as a last resort for patient protection from self harm. All orders for physical restraints will be time limited to no greater than 24 hours. A periodic assessment of the patient will be completed. The frequency and the elements of the assessment will be dependent on the type of restraint used and will conform to current hospital policy and procedures.

O. Credentialing Telemedicine Providers

The Medical Staff may rely on the "Telemedicine Providers " for primary source credential verification, other than license verification and NPDB report. The Medical Staff must evaluate credentials and make its own recommendation on telemedicine applications to the Board.