



**MOUNT CARMEL**

**Mount Carmel Health System  
Medical Staff  
Bylaws**

**Mount Carmel Health (MCE/MCGC)  
Mount Carmel St. Ann's  
Mount Carmel New Albany**

**A Medical Staff Document**

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## PREAMBLE

Mount Carmel Health System is a non-profit corporation organized under the laws of the State of Ohio for the purpose of providing health care and medical services for inpatients and outpatients and promoting the well-being of the citizens of Columbus, Ohio and the surrounding area.

The System owns and operates three (3) acute care hospitals in central Ohio: Mount Carmel St. Ann's, Mount Carmel New Albany Surgical Hospital, and Mount Carmel Health (consisting of two (2) campuses—Mount Carmel East and Mount Carmel Grove City). Mount Carmel St. Ann's and Mount Carmel New Albany Surgical Hospital each has its own Medical Staff. Mount Carmel East and Mount Carmel Grove City have a single Medical Staff known as the Medical Staff of Mount Carmel East/Grove City. For purposes of these Medical Staff Bylaws and with respect to Mount Carmel East and Mount Carmel Grove City, references to the "Hospital" means both campuses unless the context otherwise indicates.

The Board of Trustees of the System has charged the Medical Staff of each Hospital with the responsibility for providing, monitoring, and improving patient care in the Hospital. To that end, the Medical Staff of each Hospital is continually striving to achieve quality patient care for inpatients and outpatients of the System and accepts and agrees to discharge its responsibilities subject to the ultimate authority of the Board.

It is the further purpose of each Medical Staff to work with the Affiliate Hospital(s), to the extent possible, with respect to Medical Staff activities including organization, quality of care, and related peer review activities to promote good patient care within the System.

The Physicians, Dentists, Podiatrists and Psychologists practicing in the System therefore organize their activities in conformity with these Bylaws in order to carry out the functions delegated to each Medical Staff by the Board.

These Medical Staff Bylaws, while uniform, constitute the separate Medical Staff Bylaws for each Hospital within the System.

## DEFINITIONS

**"Adverse"** means a recommendation or action of the Medical Executive Committee or Board that denies, limits, or otherwise restricts Medical Staff appointment and/or Privileges on the basis of quality of care, professional conduct or competence, or as otherwise defined in the Medical Staff Bylaws.

**"Affiliate Hospital(s)"** means Mount Carmel East/Grove City, Mount Carmel St. Ann's, or Mount Carmel New Albany Surgical Hospital, as applicable.

**"Allied Health Professional" or "AHP"** means an individual other than a licensed Physician, Podiatrist, Dentist, or Psychologist who functions in a medical support role, or who exercises independent judgment within the area of his/her professional competence, and is qualified to render direct or indirect care under the supervision of or in collaboration with a Practitioner who has been granted Privileges for such care in the Hospital. AHPs may include, but are not limited to Psychologists (who hold not more than a master's degree), physician assistants, advanced practice nurses, anesthesiologist assistants, or other individuals whose scope of practice has been recognized by the Hospital.

**"Applicant"** means a Practitioner who seeks appointment to the Medical Staff and/or Privileges at the Hospital or a change in the category of appointment and/or Privileges.

**"Board of Trustees" or "Board"** means the Board of Trustees of Mount Carmel Health System.

**"Bylaws" or "Medical Staff Bylaws"** means the articles and amendments that constitute the basic governing documents of the Medical Staff. A reference to the Bylaws shall include Medical Staff Policies and Rules & Regulations as appropriate.

**"Chief Clinical Officer" or "CCO"** means the physician responsible for providing leadership and oversight of all Mount Carmel Health System clinical programs and physicians. The COO may be appointed to the Active Medical Staff.

**"Chief Executive Officer" or "CEO"** means the individual appointed by the Board to serve as the Board's representative in the overall administration of the Hospital.

**"Chief Medical Officer" or "CMO"** means the Hospital's chief medical officer. A CMO may be appointed to the Active Medical Staff.

**"CVO"** means Credentialing Verification Office.

**"Dentist"** means an individual who has received a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.") degree and who has a current license to practice dentistry.

**"Department"** means a grouping or division of clinical services as provided for in these Medical Staff Bylaws. A Department may be further divided into "Sections" led by a "Section Chief."

**"Department Chair"** means the Active Member with responsibility for Department administration as set forth in these Bylaws.

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

**"Federal Healthcare Program"** means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

**"Good Standing"** means that a Member, at the time the issue is raised, has met the attendance and Department/committee participation requirements during the previous Medical Staff Year as defined in

approved Department rules/regulations; is not in arrears in dues payments; and has not received a suspension or restriction of his/her appointment and/or Privileges in the previous twelve (12) months; provided, however, that if a Member has been suspended in the previous twelve (12) months for failure to comply with the Hospital's policies or procedures regarding medical records and has subsequently taken appropriate corrective action, such suspension shall not adversely affect the Member's Good Standing status. A Practitioner who is voluntarily not exercising his/her appointment and/or Privileges shall be considered to be in Good Standing.

**"Health System" or "System"** means Mount Carmel Health System.

**"Hospital"** means Mount Carmel Health East/Grove City (referred to as Mount Carmel East/Grove City or as Mount Carmel East or Mount Carmel Grove City when campus specific), Mount Carmel St. Ann's, or Mount Carmel New Albany Surgical Hospital, as applicable, located in Columbus, Ohio.

**"Medical Executive Committee" or "MEC"** means the executive committee of the Medical Staff.

**"Medical Staff"** means those Members with such Prerogatives and responsibilities as defined in the Medical Staff category to which each has been appointed.

**"Medical Staff Policy(ies)" or "Policy(ies)"** means those Medical Staff policies approved by the MEC and Board that serve to implement and supplement the Medical Staff Bylaws.

**"Medical Staff President"** means the Active Member who serves as chief administrative officer of the Medical Staff.

**"Medical Staff Year"** means the period from January 1 to December 31 of each calendar year.

**"Medico-Administrative Officer"** means a Practitioner employed by or otherwise serving the Hospital on a full-time or part-time basis whose duties include certain responsibilities that may be both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a Practitioner, such as to require the exercise of clinical judgment with respect to patient care and includes the supervision of professional activities of Practitioners under the Medico-Administrative Officer's direction. A full-time Medico-Administrative Officer may be appointed to the Active Medical Staff.

**"Member"** means a Practitioner who has been granted appointment to the Medical Staff. A Member must also have applied for and been granted Privileges unless the appointment is to a Medical Staff category without Privileges, or unless otherwise provided by the Bylaws.

**"Oral & Maxillofacial Surgeon"** means a Dentist who has completed a hospital-based oral and maxillofacial surgical residency accredited by the Commission on Dental Accreditation and who engages in that part of dental practice dealing with the diagnosis, surgical, and adjunctive treatment of diseases, injuries, and defects of the oral and maxillofacial regions. Oral & Maxillofacial Surgeons may obtain additional education to earn a doctor of medicine degree (M.D.) in addition to his/her dental degree.

**"Patient Encounter"** means (a) in the inpatient setting, an inpatient admission or consultation (resulting in not less than a consult report), or surgery/invasive procedure; or (b) in the outpatient setting (including the Emergency Department) treatment or consultation (resulting in not less than a consult report); provided, however, that Patient Encounters shall not include the provision of back up coverage by one Practitioner for another.

**"Physician"** means an individual who has received a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) degree and who has a current license to practice medicine.

**"Podiatrist"** means an individual who has received a Doctor of Podiatric Medicine ("D.P.M.") degree and who has a current license to practice podiatry.

**"Practitioner"** means an appropriately licensed Physician, Dentist, Podiatrist, or Psychologist.

**"Prerogative"** means the right to participate, by virtue of Medical Staff category or otherwise, granted to a Member or Allied Health Professional and subject to the ultimate authority of the Board, the conditions and limitations imposed in these Bylaws and applicable Hospital policies.

**"Privileges"** means the permission granted to a Practitioner or Allied Health Professional to render specific diagnostic, therapeutic, medical, dental, podiatric, surgical, or psychological services within the Hospital based upon the individual's professional license, experience, competence, ability and judgment.

**"Professional Liability Insurance"** means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as required and approved by the Board.

**"Psychologist"** means an individual with not less than a master's degree, or who has a doctoral degree in psychology or school psychology, or who has a doctoral degree deemed equivalent by the Ohio State Board of Psychology, with a current license to practice psychology. In the absence of exceptional circumstances, as determined by the Board upon recommendation of the MEC, a Psychologist must hold a doctoral degree in order to be a Member of the Medical Staff.

**"Quorum"** means the minimal number of Members of the Medical Staff or members of a committee who must be present for valid transaction of business.

**"Rules & Regulations"** means the compendium of rules and regulations adopted by the MEC, and approved by the Board, to govern specific administrative and patient care issues that arise at the Hospital.

**"Special Notice"** means written notice (a) sent by certified mail, return receipt requested; or (b) delivered personally with the recipient's signature as proof of receipt or other written documentation as to why such signature was not obtained.

**"Telemedicine Privileges"** means privileges for the use of electronic communication or other communication technologies to provide or support clinical care a distance. Telemedicine privileges shall include consulting, prescribing, rendering a diagnosis or otherwise providing clinical treatment to a patient using telemedicine.

## OTHER

**Authority of the Medical Staff:** Subject to the authority and approval of the Board, the Medical Staff shall exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the code of regulations of the Hospital.

**Not a Contract:** These Bylaws are not intended to and shall not create any contractual rights between the Hospital and any Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and such Practitioners.

**Time Computation:** In computing any period of time set forth in the Medical Staff governing documents, the date of the act from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday or legal holiday. When the period of time is less than seven (7) days, intermediate Saturdays, Sundays and legal holidays shall be excluded.

**Designees:** Whenever an individual is authorized to perform a duty by virtue of his/her position, then reference to such individual shall also include the individual's qualified designee.



**ARTICLE I  
NAME**

These Bylaws address the Medical Staff of Mount Carmel East/Grove City, Mount Carmel St. Ann's, and Mount Carmel New Albany Surgical Hospital, as applicable.

**ARTICLE II  
PURPOSES AND RESPONSIBILITIES**

2.1 Purposes. The purposes of the Medical Staff are:

- 2.1.1 To be accountable to the Board for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff; to oversee the quality of patient care, treatment and services provided by Practitioners and AHPs privileged through the Medical Staff process; and, to promote patient care at the Hospital that is consistent with generally recognized standards of care.
- 2.1.2 To be the formal organizational structure through which the benefits of Medical Staff appointment and Privileges are obtained and the obligations of Medical Staff appointment and Privileges are fulfilled.
- 2.1.3 To provide an appropriate and efficient forum for Practitioner input to the Board and Chief Executive Officer on applicable administrative and medical issues.

2.2 Responsibilities. The Medical Staff's responsibilities shall be:

- 2.2.1 To participate in the Hospital's performance improvement, quality review, and utilization management programs, and to conduct activities required by the Hospital to assess, maintain, and improve the quality and efficiency of medical care in the Hospital by, without limitation:
  - (a) Evaluating Practitioner/privileged AHP and organization performance through use of a valid measurement system as developed by the Hospital based upon clinically sound criteria.
  - (b) Monitoring critical patient care practices on an ongoing basis.
  - (c) Establishing criteria and evaluating credentials for appointment and reappointment to the Medical Staff, including category and Department assignments, and for Hospital Privileges.
  - (d) Initiating and pursuing corrective action against Members and AHPs with Privileges when warranted.
  - (e) Identifying and advancing, in accordance with sound resource utilization practices, the appropriate use of Hospital resources to meet patients' medical, social, and emotional needs.
- 2.2.2 To assist in the development, delivery, and evaluation of continuing medical education and training programs.
- 2.2.3 To develop, maintain, and enforce compliance with Medical Staff Bylaws that promote sound professional practices, organizational principles, and compliance with applicable law, accreditation standards, and Hospital and Medical Staff requirements.
- 2.2.4 To participate in the Hospital's strategic planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate policies, procedures and programs to meet those needs.

- 2.2.5 To fulfill the obligations and appropriately use the authority granted in these Medical Staff Bylaws in a timely manner through the use of Medical Staff officers, committees, and individuals and to account therefore to the Board.

**ARTICLE III  
APPOINTMENT AND PRIVILEGES**

- 3.1 Nature of Appointment and Privileges. Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner can be a Medical Staff Member with Privileges, a Medical Staff Member without Privileges, or be granted Privileges without a Medical Staff appointment. A Practitioner who is granted appointment to the Medical Staff is entitled to such Prerogatives and is responsible for fulfilling such obligations as are set forth in these Bylaws and the Medical Staff category to which the Practitioner is appointed. Medical Staff appointment shall confer only such Privileges, if any, as granted by the Board in accordance with these Bylaws. A Practitioner who is granted Privileges is entitled to exercise such Privileges and is responsible for fulfilling such obligations as are set forth in these Bylaws and the applicable Privilege set. No Practitioner, including those employed by or contracted with the Hospital, may admit or provide any clinical services to patients in the Hospital unless he/she has been granted Privileges to do so in accordance with the procedures set forth in these Medical Staff Bylaws.
- 3.2 Non-Discrimination. No Applicant shall be denied appointment or Privileges on the basis of gender, race, age, religion, creed, color, national origin, sexual preference, disability or a handicap unrelated to his/her ability to fulfill patient care and required Medical Staff obligations.
- Further, no qualified Applicant shall be denied appointment or Privileges based solely on whether he/she is certified to practice medicine, osteopathic medicine, or podiatry, or licensed to practice dentistry or psychology.
- 3.3 No Entitlement to Appointment and/or Privileges. No Applicant shall be entitled to Medical Staff appointment and/or Privileges at the Hospital merely by virtue of the fact that he/ she:
- 3.3.1 Holds a certain degree or a valid license/certificate to practice medicine, dentistry, podiatry, or psychology in Ohio or any other state.
  - 3.3.2 Is certified by any clinical board.
  - 3.3.3 Is a member of any professional organization.
  - 3.3.4 Has previously had a Medical Staff appointment and/or Privileges in this Hospital, or is a current or former medical staff member, or holds or has held privileges in any other hospital or health care facility.
  - 3.3.5 Contracts with or is employed by the Hospital.
- 3.4 Additional Considerations. In the case of initial applications for Medical Staff appointment and/or Privileges, and with respect to applications for new Privileges during a current appointment/Privilege period, the requested appointment/Privileges must be compatible with any policies, plans, or objectives formulated by the Board concerning:
- 3.4.1 The Hospital's patient care needs, including current and projected needs.
  - 3.4.2 The Hospital's ability to provide the facilities, equipment, personnel and financial resources that will be necessary if the application is approved.
  - 3.4.3 The Hospital's decision to contract exclusively for the provision of certain medical services with a Practitioner or a group of Practitioners other than the affected Practitioner.

- 3.5 Exclusive Contract/Closed Specialty. Hospital may enter into exclusive contracts for hospital-based Physician services (anesthesia, radiology, pathology, and emergency medicine). In the event the Hospital is considering entering into an exclusive contract for any other service in which no exclusive contract currently exists, or closing a specialty that is currently open, the following process will be followed:

The Hospital President will give at least thirty (30) days advance written notice to all active Appointees with Clinical Privileges in the potentially affected specialty ("Affected Appointees") that the Hospital is considering taking such action; and the date, location, and time when the Affected Appointees may meet with the Board (or a board appointed committee, as determined by the Board at its sole discretion) to present any information the Affected Appointees believe relevant to the decision-making process.

No Affected Appointee shall be entitled to any other procedural due process rights with respect to the decision or the effect of the contract on his/her Clinical Privileges notwithstanding any other provision of these Bylaws. The fact that a Practitioner is not able to exercise Clinical Privileges because of an exclusive contract/closed specialty does not constitute a reportable event for purposes of federal or state law.

Following the date of the scheduled meeting as provided for in the above paragraph, the Hospital President will give at least ninety (90) days advance written notice to all Affected Appointees of the earliest date in which the Hospital may enter into the exclusive contract or close the specialty.

If the Hospital enters into an exclusive contract for a service(s), any Practitioner who previously held Privileges to provide such service(s), but who is not a party to the exclusive arrangement, may not provide such service(s) as of the effective date of the Department closure or exclusive contract, irrespective of any remaining time on his/her appointment, reappointment, and/or Privilege term.

3.6 Contract Practitioners.

3.6.1 A Practitioner who is or who will be providing professional services pursuant to a contract with the Hospital is subject to all applicable qualification requirements for Medical Staff appointment and Privileges and is responsible for fulfilling all obligations related thereto.

3.6.2 The continuation and/or termination of a Medical Staff appointment and/or Privileges of any Practitioner who has a contractual relationship with the Hospital, or who is an agent, employee, principal of, member, or partner in an entity that has a contractual relationship with the Hospital shall be governed by the terms of the contract. If the contract provides for termination of Medical Staff appointment or Privileges upon expiration or termination of the contractual relationship, no right to a hearing or appellate review shall apply. If the contract is silent, then the appointment and/or Privileges shall continue subject to the Medical Staff governing documents.

- (a) In the event of any conflict between the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

3.7 Qualifications for Appointment and Privileges or for Privileges Only.

3.7.1 Every Applicant who applies for appointment and Privileges, or for Privileges only (e.g., temporary, *locum tenens*, disaster, telemedicine), must at the time of application and initial appointment/privileging and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board that he/she meets all of the following qualifications and any other qualifications and requirements as set forth in these Medical Staff Bylaws, the Hospital's code of regulations, or as otherwise hereinafter established by the Board. Each Applicant must:

- (a) Meet the continuing medical or other professional education requirements for licensure as determined by the applicable state licensure board.
- (b) Hold, as required by the applicable delineation of privileges set, a current, valid Drug Enforcement Administration ("DEA") registration. Practitioners who serve as Telemedicine Staff must hold either a current, valid DEA registration or a DEA special registration for telemedicine. This requirement does not apply to those Practitioners who hold clinical privileges in Pathology or those Practitioners in the following Medical Staff categories: Community Based, Honorary and Retired. In the event of a conflict between this §3.7.1(b) and the applicable delineation of privileges set, the applicable delineation of privileges set will control.
- (c) Have educational documentation sufficient to establish that he/she meets the definition of a Physician, Dentist, Oral Surgeon, Podiatrist, or Psychologist.
- (d) Have a current, license to practice in Ohio.
- (e) Provide documentation of successful completion of an approved internship, residency or training program, in the specialty in which the Applicant seeks Privileges, approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the Commission on Dental Accreditation of the American Dental Association, the Council on Podiatric Medical Education of the American Podiatric Medical Association, or the American Psychological Association. Fellowship in an institution approved for residency training shall be regarded as residency training or internship.
- (f) Provide documentation of board certification, as applicable, in his/her primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of General Dentistry, the American Board of Podiatric Surgery or the American Board of Professional Psychology, as applicable.
  - (i) Practitioners who attained Medical Staff appointment and Privileges prior to Board approval of these amended Bylaws and who were previously "grandfathered" regarding board certification and who have continuously held Medical Staff appointment and Privileges since that time are not required to be board certified.
  - (ii) Practitioners who are board certified as of the date of approval of these Bylaws are required maintain such board certification as provided herein.
  - (iii) Practitioners who are currently on the Medical Staff and who are not board certified but who have completed their residency or fellowship training within the last five (5) years must take his/her board certification examination in his/her primary area of practice within five (5) years from the date of completion of his/her residency or fellowship training unless an extension is otherwise recommended by the MEC and approved by the Board based upon the Practitioner's board certification requirements.
  - (iv) Practitioners who attain Medical Staff appointment and/or Privileges after Board approval of these amended Bylaws must be board certified; provided, however, that Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five (5) year(s), shall be eligible for Medical Staff

appointment and/or Privileges. In such event, in order to maintain appointment and/or Privileges, if granted, an Applicant must achieve board certification in his/her primary area of practice within five (5) years from the date of completion of his/her residency or fellowship training unless an extension is otherwise recommended by the MEC and approved by the Board based upon the Practitioner's board certification requirements.

- (v) Practitioners shall continuously maintain board certification in their primary area of practice and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements subject to the following:
  - a) If a board certified Practitioner takes and fails his/her board examination, the Practitioner may retain his/her appointment and Privileges provided he/she retakes the board examination at the next available opportunity. If the Practitioner fails his/her board examination the second time, the Practitioner's appointment and Privileges will automatically terminate at the end of the Practitioner's then current appointment/Privilege period. Practitioners in this situation may be reappointed to the Medical Staff (with Privileges) as necessary to complete the examination process provided that such periods of reappointment/regrant of Privileges shall not exceed one (1) year each.
  - b) If a Practitioner's board certification lapses during an appointment/Privilege period and if the Practitioner timely notifies Medical Staff Services of such lapse (as is required pursuant to these Bylaws and the Credentials Policy), the Practitioner may retain his/her appointment and Privileges provided s/he takes the board examination at the first available opportunity after the lapse occurs. If the Practitioner then takes but fails his/her boards, the Practitioner's appointment and Privileges shall terminate at the end of the then current appointment/Privilege period. Practitioners in this situation may receive reappointment/Privilege periods necessary to complete the examination process of not more than one (1) year at a time
  - c) Medical Staff Services shall confirm the status of a Practitioner's board certification as part of the reappointment/regrant process. If the Practitioner's board certification has lapsed during the appointment/Privilege period and the Practitioner failed to notify Medical Staff Services of such lapse, the Practitioner's appointment and Privileges shall terminate at the end of the current appointment/Privilege period based upon a failure to meet baseline qualifications. In such event, the Practitioner shall not be entitled to the additional time period as set forth in (b) above.
- (g) Have documentation evidencing an ongoing ability to provide continuous patient care, treatment, and services consistent with acceptable standards of practice and available resources including current experience, clinical results (including morbidity and mortality data, if available), and utilization practice patterns.
- (h) Have demonstrated an ability to work with and relate to other Practitioners, Allied Health Professionals, Hospital employees and administration, the Board, patients and visitors, and the community in general, in a cooperative, professional manner that maintains and promotes an environment of quality and efficient patient care.

- (i) As a precondition to the exercise of Privileges, a Practitioner must designate another Practitioner with comparable Privileges who has agreed to provide backup coverage for the Practitioner's patients in the event the Practitioner is not available.
- (j) Agree to fulfill, and fulfill, the obligations of Medical Staff appointment and Privileges as set forth in these Bylaws.
- (k) Demonstrate an ability to exercise the Privileges requested safely and competently with or without reasonable accommodation.
- (l) Be able to read and understand the English language, to communicate effectively and intelligibly in English (written and verbal), and be able to prepare medical record entries and other required documentation in a legible and professional manner.
- (m) Have and maintain current, valid Professional Liability Insurance.
- (n) Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same.
- (o) Complete such documentation as is necessary in order that the Hospital can perform a criminal background check.
- (p) Provide documentation evidencing compliance with Hospital and/or Medical Staff vaccination/immunization policies.

### 3.7.2 Waiver of Qualifications for Appointment and/or Privileges

- (a) Any Practitioner who does not satisfy one (1) or more of the criteria outlined in §3.7.1 above may request that it be waived. The Practitioner requesting the waiver bears the burden of demonstrating that the Practitioner meets or exceeds the criteria (if applicable) or that other exceptional circumstances exist justifying a waiver.
- (b) An application for appointment and/or Privileges that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted in accordance with this section.
- (c) A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the Practitioner in question, input from the relevant Department Chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the Applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the basis for such waiver.
- (d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such waiver.



- (e) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Medical Executive Committee, or other committee designated by the Board, the specific qualifications of the Practitioner in question, and the best interests of the Hospital and the communities it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other Practitioner or group of Practitioners.
- (f) No Practitioner is entitled to a waiver or to a hearing if the Board determines not to grant a waiver; rather, the decision to grant a waiver is at the sole discretion of the Board. A determination that a Practitioner is not entitled to a waiver is not a "denial" of appointment or Privileges; rather, that Practitioner is ineligible to request appointment or Privileges.

3.8 Qualifications for Appointment Only. Applicants to Medical Staff categories without Privileges must demonstrate to the satisfaction of the Medical Staff and the Board that he/she meets the qualifications for appointment set forth in the applicable Medical Staff category and as otherwise recommended by the Medical Executive Committee and approved by the Board. Such qualifications shall, at minimum, include satisfaction of licensure and professional conduct requirements.

3.9 Obligations of Appointment and/or Privileges. Each Practitioner granted an appointment with Privileges, or Privileges only, at the Hospital must, as applicable:

- 3.9.1 Provide his/her patients with professional services consistent with the recognized standards of practice in the same or similar communities and the resources locally available.
- 3.9.2 Comply with applicable law, these Medical Staff Bylaws, Rules & Regulations, the Hospital's Code of Regulations, and other applicable Hospital and Medical Staff policies and procedures including applicable vaccination policies.
- 3.9.3 Perform any Medical Staff, Department, committee, and Hospital functions for which he/she is responsible.
- 3.9.4 Complete medical records and other records in such manner and within the time period required by the Hospital for all patients he/she admits, or otherwise provides care for at the Hospital.
- 3.9.5 Abide by generally recognized standards of medical and professional ethics including, but not limited to, the Ethical and Religious Directives for Catholic Healthcare.
- 3.9.6 Satisfy ongoing continuing education requirements as applicable and as established by the Medical Staff, aid in any Medical Staff approved educational programs, and participate in continuing education programs as determined by Medical Staff Policies.
- 3.9.7 Abide by the terms of the Hospital's corporate compliance plan, and the notice of privacy practices prepared and distributed to patients as required by the federal patient privacy regulations.
- 3.9.8 Exercise the Prerogatives and satisfy the obligations of the Medical Staff category to which he/she is assigned and the Department in which he/she is a member.
- 3.9.9 Cooperate and participate, as requested by the Medical Staff, in quality assurance activities and utilization review activities, whether related to oneself or others.

- 3.9.10 Work in a cooperative, professional and civil manner and refrain from any behavior or activity that is disruptive to Hospital operations.
  - 3.9.11 Cooperate in any relevant or required review of a Practitioner's (including his/her own) credentials, qualifications or compliance with these Bylaws; and refrain from directly or indirectly interfering, obstructing or hindering any such review by withholding information, or by refusing to perform or participate in assigned responsibilities or otherwise.
  - 3.9.12 Promptly notify the Medical Staff President, Chief Medical Officer, Chief Clinical Officer, or the Hospital's Chief Executive Officer of any changes in the information provided to the Hospital by the Practitioner regarding his/her Medical Staff appointment and/or Privileges during all periods of appointment and/or grant of Privileges.
  - 3.9.13 Failure to satisfy any of the aforementioned obligations may be grounds for denial of reappointment to the Medical Staff and/or re-granting of Privileges, change in Medical Staff category, restriction or revocation of Privileges, or other corrective action pursuant to these Bylaws.
- 3.10 Obligations of Practitioners Appointed to Medical Staff Categories without Privileges. Practitioners who are appointed to Medical Staff categories without Privileges shall fulfill such Medical Staff obligations as set forth in the applicable Medical Staff category and as otherwise recommended by the MEC and approved by the Board.
  - 3.11 Duration of Appointment/Privileges. Subject to §3.5 of this Article, initial appointments and/or Privileges, modifications of Medical Staff appointment and/or Privileges, and reappointments/re-grant of Privileges shall be for a period of not more than two (2) years; provided, however, that the duration of any such initial appointment, reappointment and/or grant/re-grant of Privileges shall be subject to the provisions of the Fair Hearing Policy and may be less than two (2) years if approved by the Board. An appointment or grant of Privileges of less than two (2) years shall not be deemed Adverse for purposes of these Bylaws.
  - 3.12 Medical History and Physical Examination Requirements. Patients shall, as applicable, receive a medical history and physical examination no more than thirty (30) days prior to, or within twenty-four (24) hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting any changes in the patient's condition shall be completed within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination shall be completed and documented by a Physician, an Oral & Maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and Hospital policy (e.g. a physician assistant or advanced practice nurse may perform an H&P if granted the Privileges to do so). The medical history and physical examination, and any updates thereto, shall be recorded in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia. Additional requirements regarding completion and documentation of the medical history and physical examination are set forth in the Credentials Policy and Rules & Regulations.
  - 3.13 Medico-Administrative Positions. A Practitioner engaged by the Hospital in a purely administrative capacity with no clinical duties is subject to applicable Hospital policy and to the terms/conditions of his/her contract or employment and need not be an Appointee to the Medical Staff or have Privileges at the Hospital unless the contract or employment terms/conditions so provide. Should a Medico-Administrative Officer be granted an appointment and/or Privileges, such appointment and/or Privileges shall be granted pursuant to the applicable procedures set forth in these Bylaws and the Credentials Policy.

**ARTICLE IV  
MEDICAL STAFF CATEGORIES**

4.1 Categories. The Medical Staff shall be divided into the following categories: Active, Courtesy, Coverage, Consulting, Consulting Peer Review, Community Based, Honorary, Retired, and Affiliate.

4.1.1 Active Staff

(a) Qualifications. An Active Medical Staff Member must:

- (i) Meet the basic qualifications for Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
- (ii) Be able to respond to patients and call within the time established by the applicable Department and approved by the MEC.
- (iii) Have at least fifty (50) Patient Encounters during each two (2) year appointment/Privilege period; or, in the case of a Medico-Administrative Officer or other Practitioner who does not have clinical duties or activity, actively participate on a standing Medical Staff committee.

(b) Prerogatives. An Active Medical Staff Member may:

- (i) Exercise the Privileges granted to him/her.
- (ii) Be granted admitting Privileges.
- (iii) Attend meetings of the Medical Staff, and meetings of the Department, Section, and committees of which he/she is a member; and, vote on all matters presented at such meetings.
- (iv) Hold Medical Staff office and serve as a Department Chair, Section Chief, or committee chair.

(c) Obligations. An Active Medical Staff Member must:

- (i) Fulfill the basic obligations of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
- (ii) Contribute to the administration of the Medical Staff, including serving as a Medical Staff officer, Department Chair, or Section Chief, and on Hospital and Medical Staff committees as appointed or elected.
- (iii) Participate in the performance improvement/quality assessment and utilization review activities required of the Medical Staff.
- (iv) Discharge the recognized functions of Medical Staff appointment and Privileges by engaging in the Medical Staff's teaching and continuing education programs; attending charity patients as required; consulting with other Practitioners consistent with his/her scope of practice and Privileges; and fulfilling such other functions as may reasonably be required.

- (v) Participate in the Medical Staff self-governance process (e.g. attend Medical Staff meetings and Department, Section, and committee meetings of which he/she is a member).
- (vi) Serve on the Hospital's on-call roster for the purpose of assignment to patients who do not have an attending Practitioner, and for providing coverage and back-up coverage in the Emergency Room as required by the Medical Staff Rules & Regulations or written policy. On call obligations for Medico-Administrative Officers with no clinical duties/Privileges shall be waived. Nothing in this section precludes the Hospital from paying for on call coverage to the extent the Hospital chooses to do so.
- (vii) Promptly pay all Medical Staff dues and assessments.

4.1.2 Courtesy Medical Staff.

(a) Qualifications. A Courtesy Medical Staff Member must:

- (i) Meet the basic qualifications for Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
- (ii) Be able to respond to patients and call within the time established by the applicable Department and approved by the MEC.
- (iii) Be regularly involved in the care of patients in the Hospital with a maximum of forty-nine (49) Patient Encounters each two (2) year appointment/Privilege period. If a Member to the Courtesy Medical Staff exceeds this requirement during an appointment/Privilege period, the Member shall be transferred to the Active Medical Staff absent a showing by the Member that the number of encounters was unusual and would not be expected to occur in the upcoming appointment/Privilege period.

(b) Prerogatives. A Courtesy Medical Staff Member may:

- (i) Exercise the Privileges granted to him/her.
- (ii) Be granted admitting Privileges.
- (iii) Attend Medical Staff meetings, but shall not be entitled to vote at such meetings or hold Medical Staff office.
- (iv) Attend Department and Section meetings, but shall not be entitled to vote at such meetings or serve as a Department Chair or Section Chief.
- (v) Serve as chair or member of a Medical Staff committee and vote on committee issues; provided, however, that he/she may not serve as the chair of the Credentials Committee or in any capacity on the MEC.

(c) Obligations. A Courtesy Medical Staff Member must:

- (i) Fulfill the responsibilities of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
- (ii) If required by the Department Chair or Section Head, serve on the Hospital's on-call roster for the purpose of assignment to patients who do

not have an attending Practitioner, and for providing coverage and back-up coverage in the Emergency Room as required by the Medical Staff Rules & Regulations or written policy.

- (iii) Promptly pay all Medical Staff dues and assessments.

#### 4.1.3 Coverage Medical Staff.

- (a) Qualifications. A Coverage Medical Staff Member shall:

- (i) Meet the general qualifications of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
- (ii) Desire appointment to the Medical Staff for purposes of providing back up coverage for a Medical Staff Member with Privileges who does not otherwise have such coverage at the Hospital.
- (iii) Demonstrate participation on the medical staff at another accredited hospital or accredited ambulatory surgery center requiring performance improvement/quality assessment activities similar to those of this Hospital. The Practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at Hospital. An exception to this qualification may be made by the Board provided the Practitioner is otherwise qualified by education, training, and experience to provide the requested service.

- (b) Prerogatives. A Coverage Medical Staff Member may:

- (i) Exercise the Privileges granted to him/her; provided, however, that he/she may not admit patients to the Hospital except under the name of the Practitioner for whom the Coverage Medical Staff Member is providing back up coverage.
- (ii) Attend Medical Staff meetings, but shall not be entitled to vote at such meetings or hold Medical Staff office.
- (iii) Attend Department and Section meetings, but shall not be entitled to vote at such meetings or serve as a Department Chair or Section Chief.
- (iv) Not serve as a committee member or chair.

- (c) Obligations. A Coverage Medical Staff member must:

- (i) Fulfill the requirements of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
- (ii) Promptly pay all Medical Staff dues and assessments.

#### 4.1.4 Consulting Medical Staff.

- (a) Qualifications. A Consulting Medical Staff Member must:

- (i) Meet the general qualifications of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.

- (ii) Possess specialized skills needed at the Hospital for a specific project or for consultation on an occasional basis when requested by an Active or Courtesy Medical Staff Member.
- (iii) Demonstrate participation on the medical staff at another accredited hospital or accredited ambulatory surgery center requiring performance improvement/quality assessment activities similar to those of this Hospital. The Practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at Hospital. An exception to this qualification may be made by the Board provided the Practitioner is otherwise qualified by education, training, and experience to provide the requested service.

(b) Prerogatives. A Consulting Medical Staff Member may:

- (i) Exercise the Privileges granted to him/her; provided, however, that a Consulting Medical Staff Member shall not be granted admitting Privileges.
- (ii) Attend Medical Staff meetings, but shall not be entitled to vote at such meetings or hold Medical Staff office.
- (iii) Attend Department and Section meetings, but shall not be entitled to vote at such meetings or serve as a Department Chair or Section Chief.
- (iv) Not serve as a committee member or chair.

(c) Obligations. A Consulting Medical Staff Member shall:

- (i) Fulfill the requirements of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
- (ii) Promptly pay all Medical Staff dues and assessments.

4.1.5 Consulting Peer Review Medical Staff.

(a) Qualifications. A Consulting Peer Review Medical Staff Member must:

- (i) Practice either locally or in another city and/or state in which he/she has a valid license to practice.
- (ii) Possess skills needed at the Hospital for a specific peer review project or for peer review consultation on an occasional basis when requested by Hospital administration, the Board, or a Medical Staff committee.
- (iii) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of Hospital.

(b) Prerogatives. A Consulting Peer Review Medical Staff Member may:

- (i) Review selected medical record components, organizational information, and peer review materials retained by the Hospital for the purpose of rendering an opinion on the quality of health care rendered to patients at the Hospital or otherwise perform related peer review services as specifically requested.

- (ii) Not be granted Privileges to admit or treat patients.
- (c) Obligations. A Consulting Peer Review Medical Staff Member shall:
  - (i) Perform such duties as are requested by the MEC and which he/she agrees to perform.
  - (ii) Attend Medical Staff, Department, Section, and committee meetings, as requested, but shall not be entitled to vote at such meetings, hold Medical Staff office, or serve as a Department Chair, Section Chief, or committee chair.
  - (iii) Not be charged Medical Staff dues.

4.1.6 Community-Based Medical Staff.

- (a) Qualifications. A Community-Based Medical Staff Member must:
  - (i) Satisfy the basic qualifications for Medical Staff appointment as recommended by the MEC and approved by the Board.
  - (ii) Provide medical, dental, podiatric, or psychological services to patients in the community the Hospital serves; or be a previous Medical Staff Member who chooses to work for a governmental agency without membership on any other hospital medical staff.
- (b) Prerogatives. A Community-Based Medical Staff Member may:
  - (i) Not have Privileges at the Hospital.
  - (ii) Visit his/her patients who are in the Hospital and review those patients' medical records consistent with the Hospital's medical records policy.
  - (iii) Not write orders or progress notes, make notations in the medical record, or otherwise actively participate in the provision of care or management of patients at the Hospital.
  - (iv) Attend any Medical Staff or Hospital education activity.
  - (v) Attend Medical Staff meetings, but shall not be entitled to vote at such meetings or hold Medical Staff office.
  - (vi) Attend Department and Section meetings, but shall not be entitled to vote at such meetings or serve as Department Chair or Section Chief.
  - (vii) Not serve as a committee member or chair.
- (c) Obligations. A Community-Based Medical Staff Member must:
  - (i) Fulfill such obligations as recommended by the MEC and approved by the Board.
  - (ii) Promptly pay Medical Staff dues and assessments.

4.1.7 Honorary Medical Staff.

(a) Qualifications.

- (i) The Honorary Medical Staff shall consist of Practitioners retired from practice and recognized for their excellent reputations, their contributions to health and medical sciences, and/or their long-standing service to the Hospital.
- (ii) Appointment to this category shall be made by the Board upon recommendation of the Board or the Active Medical Staff.

(b) Prerogatives. Honorary Medical Staff Members may:

- (i) Not be granted or exercise any Privileges at the Hospital.
- (ii) Attend any Medical Staff or Hospital education activity.
- (iii) Attend Medical Staff meetings, but shall not be entitled to vote at such meetings or hold Medical Staff office.
- (iv) Attend Department and Section meetings, but shall not be entitled to vote at such meetings or serve as a Department Chair or Section Chief.
- (v) Serve as a member of a Medical Staff committee and vote on committee issues; provided, however, that he/she may not serve as a committee chair or as a member of the MEC.

(c) Obligations. Honorary Medical Staff Members shall:

- (i) Have no assigned duties or responsibilities.
- (ii) Not be charged Medical Staff dues.

4.1.8 Retired Medical Staff.

(a) Qualifications. The Retired Medical Staff shall consist of Practitioners retired from practice.

(b) Prerogatives. Retired Medical Staff Members may:

- (i) Not be granted or exercise any Privileges at the Hospital.
- (ii) Attend any Medical Staff or Hospital education activity.
- (iii) Attend Medical Staff meetings, but shall not be entitled to vote at such meetings or hold Medical Staff office.
- (iv) Attend Department and Section meetings, but shall not be entitled to vote at such meetings or serve as a Department Chair or Section Chief.
- (v) Serve as a member of a Medical Staff committee and vote on committee issues; provided, however, that he/she may not serve as a committee chair or as a member of the MEC.



- (c) Obligations. Retired Medical Staff Members shall:
  - (i) Have no assigned duties or responsibilities.
  - (ii) Not be charged Medical Staff dues.

4.1.9 Affiliate Medical Staff.

- (a) Qualifications.
  - (i) Appointment to this category shall be automatic for Affiliate Hospital Medical Staff officers, Department Chairs, Credentials Committee and Quality Committee members, Chief Medical Officers, and Chief Clinical Officer during the term of such Practitioner's office or position, as applicable, at the Affiliate Hospital. Appointment to this category shall be without Privileges and shall automatically terminate at such time as the Practitioner no longer holds the applicable office or position at the Affiliate Hospital. The primary purpose of this category is to provide for broad collaboration between Affiliate Hospital medical staffs to promote and further effective peer review and quality of care to patients. Practitioners automatically appointed to this category may apply for Medical Staff appointment at the Hospital in a different category if they qualify and desire to be so appointed or to seek Privileges.
  - (ii) Appointment to the Affiliate Medical Staff may be requested by Practitioners who are appointed to the Active Medical Staff with Privileges at an Affiliate Hospital(s) in accordance with the process set forth in §2.4.3 of the Credentials Policy.
- (b) Prerogatives. An Affiliate Medical Staff Appointee:
  - (i) May attend meetings of the Medical Staff and appropriate Department and Section meetings (without vote).
  - (ii) Has no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).
  - (iii) May attend educational programs of the Medical Staff.
  - (iv) May refer patients to Appointees of the Active Medical Staff for admission and/or treatment.
  - (v) May visit his/her patients when hospitalized and review their medical records (provided the patient consents) but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to patients.
  - (vi) May refer patients to the Hospital's diagnostic and treatment facilities.
  - (vii) May not be granted Privileges and may not admit or treat patients at the Hospital.
  - (viii) May not hold Medical Staff office or serve as a Department Chair or Section Chief, except that he/she may serve as the chair of a special committee.

- (c) Obligations. An Affiliate Medical Staff Appointee may:
  - (i) Fulfill such obligations as recommended by the MEC and approved by the Board.
  - (ii) Not be required to pay Medical Staff dues.

#### 4.1.10 Telemedicine Staff

- (a) Qualifications. A Telemedicine Staff Medical Staff Member shall:
  - (i) Meet the general qualifications of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
  - (ii) Maintain current Ohio licensure or current registration as a telemedicine provider through the Ohio State Medical Board.
  - (iii) Desire appointment to the Medical Staff for purposes of providing Telemedicine services.
- (b) Prerogatives. A Telemedicine Staff Medical Staff Member may:
  - (i) Exercise the Privileges granted him/her only from a distant site.
  - (ii) Not admit patients to the Hospital.
  - (iii) Not exercise Privileges in the Hospital.
  - (iv) Attend Medical Staff meetings, but shall not be entitled to vote at such meetings or hold Medical Staff office.
  - (v) Attend Department and Section meetings, but shall not be entitled to vote at such meetings or serve as Department Chair or Section Chief.
  - (vi) Not serve as a committee member or chair.
- (c) Obligations. A Telemedicine Staff Medical Staff Member shall:
  - (i) Fulfill the requirements of Medical Staff appointment and Privileges set forth in the Medical Staff Bylaws.
  - (ii) Promptly pay all Medical Staff dues and assessments.

**ARTICLE V  
CREDENTIALING, APPOINTMENT/  
REAPPOINTMENT AND PRIVILEGING PROCEDURES**

- 5.1 Process. Unless otherwise provided in these Bylaws or the Credentials Policy:
- 5.1.1 Applications for appointment, reappointment, and/or Privileges shall be submitted to the Credentialing Verification Office who shall review each application for completeness and perform primary source verification.
  - 5.1.2 Upon completion of the collection and verification process, the completed application and all supporting documents shall be reviewed by the applicable Department Chair, the Credentials Committee, and the MEC.
  - 5.1.3 Initial appointments and reappointments to the Medical Staff and/or the granting/regranting of Privileges shall be made by the Board, or as otherwise provided in accordance with the Bylaws.
  - 5.1.4 The Board shall act on appointments, reappointments, and/or Privileges only after there has been a recommendation from the MEC, unless otherwise authorized by these Bylaws or the governing documents of the Hospital. If the MEC fails to make a recommendation within the time required, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same type of criteria considered by the MEC.
  - 5.1.5 Disaster Privileges may be granted to volunteer licensed independent practitioners (and AHPs) when the Hospital's emergency operations plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs. The Chief Executive Officer or Medical Staff President may grant such disaster Privileges on a case-by-case basis in accordance with the requirements set forth in the Credentials Policy (or AHP Policy, as applicable).
  - 5.1.6 Temporary privileges may be granted to licensed independent practitioners (and AHPs) while waiting final approval of a completed application or in order to meet an important patient care need. Upon recommendation of the Medical Staff President, the Hospital CEO may grant temporary Privileges on a case-by-case basis in accordance with the requirements set forth in the Credentials Policy (or AHP Policy), as applicable. Temporary privileges granted to licensed independent practitioners waiting final approval of a completed application may not exceed one hundred twenty (120) days. Temporary privileges granted to licensed independent practitioners in order to meet an important patient care need are granted for an initial period of thirty (30) days and may be renewed for additional thirty (30) day periods as necessary.
- 5.2 Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation. All Practitioners who are granted Privileges must undergo a focused professional practice evaluation and be subject to an ongoing professional practice evaluation as outlined in the Credentials Policy.
- 5.3 Details. The detailed procedures for credentialing, for evaluating applications for initial appointment to the Medical Staff, for conducting appraisals for reappointment to the Medical Staff, and for the delineation, granting and re-granting of Privileges are outlined in the Credentials Policy.

**ARTICLE VI  
MEDICAL STAFF OFFICERS AND MEC MEMBERS AT LARGE**

- 6.1 Officers of the Medical Staff. The officers of the Medical Staff shall consist of a Medical Staff President, President-elect, and immediate past Medical Staff President.
- 6.1.1 For purposes of Mount Carmel East/Grove City, the Medical Staff officers shall include the Clinical Department Council ("CDC") chairs, one (1) of whom shall serve as the President-elect.
- 6.2 Qualifications. Each Medical Staff officer and MEC member at large shall:
- 6.2.1 Be board certified and a Member in Good Standing to the Active Medical Staff at the time of nomination and election, and remain in Good Standing throughout his/her term. Any officer or MEC member at large who fails to maintain such status shall immediately be removed from his/her office or position.
- 6.2.2 Have been recognized for a high level of clinical competence in his/her field and have demonstrated executive and administrative ability through active participation in Medical Staff activities and other experience.
- 6.2.3 Have demonstrated a high level of interest in and support of the Medical Staff and Hospital by his/her Medical Staff tenure and his/her level of clinical activity at the Hospital.
- 6.2.4 Willingly and faithfully exercise the duties and authority of the office or position held and cooperate and work with the other officers, Department Chairs, Section Chiefs, the Chief Executive Officer, the Board and their respective committees.
- 6.3 Nominations and Election.
- 6.3.1 A nominating committee must be appointed and shall consist of not more than five (5) members to include the immediate past and current Medical Staff President, one (1) other Active Medical Staff Member appointed by the Medical Staff President, and additional members appointed in consultation with the Department Chairs. The nominating committee shall offer one (1) or more nominees for the office of, as applicable:
- (a) Mount Carmel East/Grove City: CDC Chair
- (b) Mount Carmel St. Ann's: President-elect and MEC member at large positions
- (c) Mount Carmel New Albany: President-elect.
- 6.3.2 All nominees shall be elected by a majority vote of those Active Medical Staff Members in Good Standing and approved by the Board. If there are three (3) or more candidates for the office or position and no candidate receives a majority of the votes cast, the name of the candidate who receives the fewest votes will be omitted from successive ballots until a majority vote is obtained by one (1) candidate.
- 6.3.3 Mount Carmel East/Grove City MEC members at large shall be appointed from the membership of the Mount Carmel East and Mount Carmel Grove City Clinical Department Councils by the Clinical Department Council chairs in consultation with the council members.

#### 6.4 Succession

6.4.1 The President shall automatically succeed to the office of immediate past Medical Staff President upon completion of his/her term as Medical Staff President.

#### 6.4.2 Mount Carmel East/Grove City

- (a) The President of the Medical Staff attains office by automatic and alternate succession from the office of the CDC chair of each Hospital.
- (b) The applicable CDC chair shall automatically succeed to the office of the President-elect.

6.4.3 Mount Carmel St. Ann's: The President-elect shall automatically succeed to the office of the Medical Staff President upon completion of his/her term as President-elect.

6.4.4 Mount Carmel New Albany: The President-elect shall automatically succeed to the office of the Medical Staff President upon completion of his/her term as President-elect.

#### 6.5 Term.

6.5.1 Mount Carmel St. Ann's and Mount Carmel New Albany: Officers and MEC members at large shall take office on January 1 following their election/appointment and shall serve a two (2) year term. MEC members at large may be re-elected/reappointed for one (1) additional term up to a maximum of two (2) consecutive terms. Each MEC member at large shall serve until the end of his/her term or until a successor is elected/appointed, unless he/she sooner resigns or is removed from his/her office or position.

#### 6.5.2 Mount Carmel East/Grove City:

- (a) **President and Immediate Past President**: The President and the Immediate Past President shall serve a one (1) year term, commencing January 1, and serving until a successor is named unless he/she shall resign sooner or be removed from office.
- (b) **CDC Chair**: The CDC Chair shall serve two (2) year staggered terms, commencing January 1, and serving until a successor is elected unless he/she shall resign sooner or be removed from office.
- (c) **MEC members at large**: MEC members at large shall take office on January 1 following their election/appointment and shall serve a two (2) year term. MEC members at large may be re-elected/reappointed for one (1) additional term up to a maximum of two (2) consecutive terms. Each MEC member at large shall serve until the end of his/her term or until a successor is elected/appointed, unless he/she sooner resigns or is removed from his/her office or position.

#### 6.6 Vacancies.

6.6.1 If there is a vacancy in the office of the Medical Staff President, the Medical Staff President-elect shall serve out the remaining term.

6.6.2 If there is a vacancy in the office of immediate past President, the current Medical Staff President shall appoint a former Medical Staff President to serve out the remaining term subject to MEC approval.

- 6.6.3 Mount Carmel East/Grove City: A vacancy in the office of CDC chair shall be filled by appointment of the CDC with approval of the MEC for the remainder of the term. A vacancy in a Mount Carmel East/Grove City MEC member at large position shall be filled in the same manner in which the original appointment was made.
- 6.6.4 Mount Carmel St. Ann's: A vacancy in the office of President-elect or in a Mount Carmel St. Ann's MEC member at large position shall be filled, on an interim basis, by appointment of the MEC. In such event, an election for a new President-elect or MEC member at large shall be held thereafter, as soon as possible, in accordance with §6.3.
- 6.6.5 Mount Carmel New Albany: A vacancy in the office of President-elect shall be filled, on an interim basis, by appointment of the MEC. In such event, an election for a new President-elect shall be held thereafter, as soon as possible, in accordance with §6.3.

6.7 Resignation and Removal.

6.7.1 Resignation. Any officer of the Medical Staff or MEC member at large may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt or at any later time specified therein.

6.7.2 Removal.

- (a) Mechanism. An officer of the Medical Staff or MEC member at large may be removed by a majority vote of the Board, by a two-thirds (2/3) vote of the MEC, or by a two-thirds (2/3) vote of the Active Members in Good Standing attending and voting at a special meeting called for that purpose. The officer or MEC member at large subject to the removal action shall be given ten (10) days prior written notice of the meeting of the Medical Staff, MEC or Board, as applicable, and shall be given an opportunity to speak on his/her own behalf at said meeting prior to a vote being taken.
- (b) Grounds. Permissible grounds for removal of a Medical Staff officer or MEC member at large include, but are not limited to:
- (i) Failure to perform the duties of the office or position held in a timely and appropriate manner.
  - (ii) Failure to continuously satisfy the qualifications for the office or position.
  - (iii) The imposition of a summary suspension, an automatic suspension or termination, or any other corrective action undertaken against the officer or member at large which results in a final Adverse decision.
  - (iv) Conduct or statements detrimental to the interests of the Medical Staff or the Hospital or to their goals, programs, or public image.
  - (v) Physical or mental infirmity that renders the officer or member at large incapable of fulfilling the duties of his/her office or position.

6.8 Duties of Officers. The duties, responsibilities and authority of the Medical Staff officers and MEC members at large are as set forth in the Organization Policy.

**ARTICLE VII  
CLINICAL DEPARTMENTS**

**7.1 Current Departments; Affiliation.**

7.1.1 Every Practitioner must have a primary affiliation with the Department that most clearly reflects his/her professional training and experience in the clinical area in which his/her practice is concentrated. A Practitioner may be granted Privileges in one or more Departments, and his/her exercise of Privileges within the jurisdiction of any Department is subject to the rules and regulations of that Department and the authority of the Department Chair.

7.1.2 The Medical Staff shall be organized in the following clinical Departments:

- (a) Mount Carmel St. Ann's Medical Staff Departments: Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Obstetrics and Gynecology, Orthopedic Surgery, Pathology, Pediatrics, Radiology, Surgery.
- (b) Mount Carmel New Albany Medical Staff Departments: Surgery, Hospital Based (Anesthesiology, Radiology, Pathology), Medicine.
- (c) Mount Carmel East Medical Staff Departments: Anesthesiology, EENT, Family Medicine, Medicine, OB/GYN, Orthopedics, Radiology, Surgery.
- (d) Mount Carmel Grove City Medical Staff Departments: Anesthesiology, EENT, Family Medicine, Medicine, OB/GYN, Orthopedics, Psychiatry, Radiology, Surgery.
- (e) Mount Carmel Health Central Medical Staff Departments:
  - (i) Cardiothoracic Surgery
  - (ii) Cardiovascular Medicine
  - (iii) Emergency Medicine
  - (iv) Pathology and Laboratory Medicine

The chairs of the Departments of Cardiothoracic Surgery, Cardiovascular Medicine, Emergency Medicine, and Pathology and Laboratory Medicine will be voting members of the Clinical Department Councils at Mount Carmel East and Mount Carmel Grove City.

**7.2 Department Chair: Qualifications, Election, and Term.**

7.2.1 Qualifications. Each Department shall have a Department Chair who must be an Active Medical Staff Member and a member of the applicable Department; remain in Good Standing throughout his/her term; and be willing and able to faithfully discharge the functions of his/her position. The Department Chair shall be board certified by an appropriate specialty board.

7.2.2 Election. The current Department Chair shall, sufficiently in advance of the end of his/her term, create a nominating committee to solicit names and issue a slate of candidates for the Department Chair position. Department Chair elections shall take place at a Department meeting at which a quorum is present. Advance notice of the election will be provided to Department members through the applicable meeting notice. Election of a

Department Chair requires a majority vote of Department members eligible to vote, in Good Standing, and present at a Department meeting at which a quorum is present. In the event that the election cannot be held during the Department meeting (e.g., due to lack of quorum), the election will be held by mail/electronic ballot, and election of the Department Chair shall require a majority vote of the Department members eligible to vote, in Good Standing, who submit ballots prior to the deadline set forth in the notice advising of the purpose for which a vote is to be taken. If there are three (3) or more candidates for a Department Chair position and no candidate receives a majority of the votes cast, the name of the candidate who receives the fewest votes will be omitted from successive ballots until a majority vote is obtained by one (1) candidate. Election of Department Chairs is subject to ratification by the MEC and Board. Voting must occur sufficiently in advance so that election results can be sent to the Board for approval at the last regularly scheduled Board meeting of the year.

7.2.3 The Department Chair will serve a two (2) year term commencing January 1 following his/her election and continuing until his/her successor is chosen, unless he/she sooner resigns or is removed from his/her position. A Department Chair may serve for an unlimited number of successive terms.

7.3 Department Chair: Responsibilities and Authority. Each Department Chair shall:

7.3.1 Be responsible for all clinically and administratively-related activities of the Department, unless otherwise provided for by the Hospital, and report on such activities as requested by the Chief Executive Officer, the MEC, or the Board.

7.3.2 Survey, on a continuous basis, the professional performance of all individuals in the Department who have delineated Privileges, including but not limited to monitoring adherence to Medical Staff, Hospital, and Department policies and procedures for: obtaining consultation, alternate coverage, unexpected patient care management events, patient safety, and adherence to sound principles of clinical practice.

7.3.3 Recommend to the Medical Staff the criteria for Privileges that are relevant to the care provided in the Department.

7.3.4 Recommend Privileges for each member of the Department.

7.3.5 Assess and recommend to the relevant Hospital authority off site sources for needed patient care, treatment, and services not provided by the Department or the Hospital.

7.3.6 Integrate the Department into the primary functions of the Hospital.

7.3.7 Coordinate and integrate interdepartmental and intradepartmental services.

7.3.8 Develop, as necessary, and implement policies and procedures that guide and support the provision of care, treatment, and services in the Department.

7.3.9 Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services in the Department.

7.3.10 Determine the qualifications and competence of Department personnel who are not Practitioners and who provide patient care, treatment, and services in the Department.

7.3.11 Continually assess and improve the quality of care, treatment, and services provided in the Department.



- 7.3.12 Maintain quality control programs, as appropriate, in the Department.
- 7.3.13 Provide for orientation and continuing education of all persons in the Department.
- 7.3.14 Make recommendations for space and other resources needed by the Department.
- 7.3.15 Developing and maintaining an appropriate call schedule acceptable to Administration (recognizing the right of Administration to create such a schedule in the event the Department Chair does not).

7.4 Department Chair: Resignation or Removal from Position.

7.4.1 Resignation. A Department Chair may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt or at any later time specified therein.

7.4.2 Removal of Department Chair from Position. Removal of a Department Chair requires a majority vote of the Board; a two-thirds (2/3) vote of the MEC; or, a two-thirds (2/3) vote of the Department members eligible to vote, and in Good Standing initiated by a petition signed by at least thirty percent (30%) of the Department members. Permissible grounds for removal of a Department Chair include, but are not limited to:

- (a) Failure to perform the duties of the position held in a timely and appropriate manner.
- (b) Failure to continuously satisfy the qualifications for the position.
- (c) The imposition of a summary suspension, an automatic suspension or termination, or any other corrective action undertaken against the Department Chair which results in a final Adverse decision.
- (d) Conduct or statements detrimental to the interests of the Medical Staff or the Hospital or to their goals, programs, or public image.
- (e) Physical or mental infirmity that renders the Department Chair incapable of fulfilling the duties of his/her position

7.4.3 Vacancy. A vacancy in a Department Chair position will be filled, on an interim basis, by the MEC through appointment of an acting Department Chair subject to Board approval. In such event, an election for a new Department Chair shall be held thereafter, as soon as possible, in accordance with §7.2.2.

7.5 Department Vice-Chairs. Each Department shall have a Department Vice-Chair who will be appointed, and who may be removed, by the Department Chair in consultation with the MEC. Department Vice-Chairs shall be subject to the same qualifications, term, and resignation requirements set forth in this Article for Department Chairs. A vacancy in a Department Vice-Chair position shall be filled in the same manner in which the original appointment was made.

## ARTICLE VIII COMMITTEES

### 8.1 Peer Review Committees

- 8.1.1 The Medical Staff as a whole and each committee provided for by these Bylaws is hereby designated as a peer review committee as that term is defined in Ohio Revised Code §2305.25 and .251. The Medical Staff, through its committees, shall be responsible for evaluating, maintaining, and/or monitoring the quality and utilization of the Hospital's health care services.
- 8.1.2 In carrying out his/her duties under these Bylaws, whether as a committee member, Department Chair, Section Chief, Medical Staff officer or otherwise, each Practitioner shall be acting in his/her capacity as a peer review committee member and designated agent of the Medical Staff.
- 8.1.3 Such peer review committees and its designated agents may, from time to time and/or as specifically provided herein, appoint Hospital administrative personnel as their agent in carrying out such peer review duties.

### 8.2 Medical Executive Committee

- 8.2.1 Composition. The MEC shall be a standing committee of the Medical Staff and shall consist of the following voting members:

- (a) Mount Carmel St. Ann's: the Medical Staff President, President-elect, immediate past Medical Staff President, Credentials Committee chair (appointed/removed by the Medical Staff President), the Department Chairs, and two (2) members at large.
- (b) Mount Carmel East/Grove City: the Medical Staff President, the CDC chairs (one of whom shall serve as the President-elect), immediate past Medical Staff President, Credentials Committee chair (appointed/removed by the Medical Staff President), and four (4) members at large selected from the Clinical Department Councils.
- (c) Mount Carmel New Albany: the Medical Staff President, President-elect, immediate past Medical Staff President, Credentials Committee chair (appointed/removed by the Medical Staff President), and the Department Chairs.
- (d) All Active Medical Staff Members, of any discipline or specialty, are eligible for membership on the MEC. At all times, Physician Members of the Active Medical Staff shall comprise at least a majority of the voting members of the MEC; provided, however, that the MEC may also include other Practitioners. The Medical Staff President shall act as chair (with vote), and a representative of the Medical Staff Services shall act as support staff to the MEC. The Chief Executive Officer shall be entitled to attend all MEC meetings in an *Ex Officio* capacity.

- 8.2.2 Duties. The MEC shall:

- (a) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws and/or the Hospital's code of regulations, between Medical Staff meetings.
- (b) Coordinate the activities and general policies of the various Medical Staff Departments and Sections.

- (c) Make recommendations to the Board regarding the MEC's review of and actions on reports and recommendations of Medical Staff committees, Departments, Sections, and other assigned activity groups.
- (d) Implement policies of the Medical Staff including, but not limited to, enforcement of the Medical Staff Bylaws and Rules & Regulations, the Hospital's code of regulations, and other applicable Medical Staff and Hospital policies and procedures.
- (e) Serve as a liaison between the Medical Staff, the Chief Executive Officer, and the Board.
- (f) Ensure that the Medical Staff is kept abreast of the Hospital's accreditation program and informed of the accreditation status of the Hospital.
- (g) Review the credentials of all Practitioners/AHPs applying for Medical Staff appointment and/or Privileges and make recommendations to the Board regarding Medical Staff appointment, Department/Section assignments, and individual delineation of Privileges.
- (h) Review, at least every two (2) years, all information available regarding the performance and clinical competence of Practitioners/AHPs with Privileges and, as a result of such reviews, make recommendations for, as applicable, reappointments and/or re-granting or changes in Privileges to the Board.
- (i) Take reasonable steps to ensure professional, ethical conduct, and competent clinical performance by Practitioners/AHPs with, as applicable, Medical Staff appointment and/or Privileges, including the initiation of and/or participation in Medical Staff/AHP corrective action or review procedures when warranted and implementation of any actions taken as a result thereof.
- (j) Report at general Medical Staff meetings regarding the proceedings of all meetings and decisions made regarding Medical Staff policy in the interim between Medical Staff meetings.
- (k) Make recommendations on Hospital management matters (such as long-range planning) to the Board.
- (l) Make recommendations to the Board regarding Medical Staff structure; participation of the Medical Staff in performance improvement/quality assessment and utilization review activities; and mechanisms for Privileges delineation, credentials review, termination of Medical Staff appointment and/or Privileges, and fair hearing procedures.
- (m) Organize the Medical Staff's performance improvement/quality assessment, quality review, and utilization management activities and establish a mechanism to conduct, evaluate, and revise such activities.
- (n) Request evaluation of Practitioners/AHPs privileged through the Medical Staff process in instances where there is doubt about the Practitioner's/AHP's ability to perform the Privileges requested.

8.2.3 Meetings. The MEC shall meet at least ten (10) times per year and otherwise at the call of the Medical Staff President.

- 8.3 Other Medical Staff Committees. The composition, duties and meeting requirements for additional Medical Staff committees are set forth in the Organization Policy.

**ARTICLE IX  
MEDICAL STAFF, DEPARTMENT, SECTION, AND COMMITTEE MEETINGS**

The procedures regarding the conduct of Medical Staff, Department, Section, and committee meetings are set forth in the Organization Policy.

**ARTICLE X  
CORRECTIVE ACTION, SUMMARY SUSPENSION,  
AUTOMATIC SUSPENSION/TERMINATION**

**10.1 Collegial Intervention.**

10.1.1 Prior to initiating corrective action against a Member for professional conduct or competency concerns, the Medical Staff leadership or Board (through the Chief Executive Officer as its administrative agent) may elect to attempt to resolve the concern(s) informally.

10.1.2 Nothing in this section shall be construed as obligating the Hospital or Medical Staff leadership to engage in informal remediation prior to implementing formal corrective action on the basis of a single incident.

**10.2 Corrective Action.**

10.2.1 Grounds for Corrective Action. Corrective action against a Member may be initiated whenever the Member engages in or exhibits actions, statements, demeanor, or conduct, either within or outside the Hospital, that is, or is reasonably likely to be:

- (a) Contrary to the Medical Staff Bylaws, Rules & Regulations, the Hospital's code of regulations or other applicable Hospital or Medical Staff policies or procedures.
- (b) Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.
- (c) Disruptive to Hospital operations.
- (d) Damaging to the Medical Staff's or the Hospital's reputation.
- (e) Below the applicable standard of care.

10.2.2 Authorization to Initiate. Any of the following may request that corrective action be taken or initiated:

- (a) An officer of the Medical Staff.
- (b) A Chair of any Department in which the Member exercises Privileges.
- (c) Any standing committee or subcommittee of the Medical Staff (including the MEC) or a chair thereof.
- (d) The Chief Executive Officer.
- (e) The Board or the chair thereof.

10.2.3 Initiation, Requests, Notices. All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. The request must include reference to the specific activities or conduct which constitute the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis for its recommendation in its minutes. The Medical Staff President shall promptly notify the Chief Executive Officer in writing of all such requests.

10.2.4 Investigation. Upon receipt of a request for corrective action, the MEC shall act on the request. The MEC's investigation shall be deemed to begin as of the start of the MEC meeting at which the request for corrective action is to be presented to it. The MEC may conduct such investigation itself, assign the task to a standing or ad hoc committee, or may refer the matter to the Board for investigation and resolution. This investigative process is not a "hearing" as that term is used in the Fair Hearing Policy and shall not entitle the Member to the procedural rights provided therein. The investigative process may include, without limitation, a meeting with the Member involved; with the individual or group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved. If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by minutes, to the MEC as soon as is practical after its receipt of the assignment to investigate. The MEC may, at any time in its discretion, and shall, at the request of the Board, terminate the investigative process and proceed with action as provided below. If the investigating group or individual has reason to believe that the Member's conduct giving rise to the request for corrective action was the result of a physical or mental impairment, the MEC may either refer the matter to the Peer Support Committee or require the Member to submit to an impartial physical or cognitive evaluation within a specified time and pursuant to guidelines set forth in the Practitioner Wellness Policy. The MEC shall select the independent, third party service provider who will conduct the examination at the Member's expense.

10.2.5 MEC Action. As soon as practical after the conclusion of the investigative process, if any, the MEC shall act upon the request for corrective action. Its action may include, without limitation, the following:

- (a) Rejection of the request for corrective action.
- (b) Issuance of a verbal warning or a letter of reprimand.
- (c) Imposition of a focused professional practice evaluation with retrospective review of cases and/or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision.
- (d) Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Member's ability to exercise Privileges.
- (e) Recommendation of reduction, suspension, or revocation of all or any part of the Member's Privileges.
- (f) Recommendation of reduction of Medical Staff category or limitation of any Medical Staff Prerogatives directly related to the Member's delivery of patient care.
- (g) Recommendation of suspension or revocation of the Member's Medical Staff appointment.

10.2.6 Effect of MEC Recommendation and Board Action.

- (a) Adverse Recommendation by MEC. When the MEC's recommendation is Adverse to the Member, the Chief Executive Officer shall inform the Member by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural rights contained in the Fair Hearing Policy. The MEC's recommendation shall not be forwarded to the Board for a final decision until after the Member has exercised or waived his/her procedural due process rights.

- (b) Failure to Act by MEC. If the MEC fails to act in processing and recommending action on a request for corrective action within an appropriate time as determined by the Board, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same information considered by the MEC.
  - (i) If the Board's action is favorable, the action shall be effective as its final decision.
  - (ii) If the Board's decision is Adverse to the Member, the Board shall inform the Member by Special Notice and the Member shall be entitled, upon timely and proper request, to the procedural rights set forth in the Fair Hearing Policy. The Board will not make a final decision regarding the matter until the Member has exercised or waived his/her procedural due process rights.

10.2.7 Other Action.

- (a) The commencement of corrective action procedures against a Member shall not preclude the summary suspension or automatic suspension or termination of the Medical Staff appointment and/or all, or any portion, of the Member's Privileges in accordance with the procedures set forth in §§10.3, 10.4 and 10.5 of this Article.

10.3 Summary Suspension.

10.3.1 Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect the life, health or safety of any patient(s) or to reduce the substantial likelihood of injury to any patient, employee, or other person present in the Hospital, any of the following have the authority to summarily suspend the Medical Staff appointment and/or all, or any portion of, the Privileges of such Practitioner:

- (a) The Medical Staff President
- (b) The President-elect or CDC chairs
- (c) The applicable Department Chair
- (d) The Chief Executive Officer, Chief Medical Officer, or Chief Clinical Officer, after conferring, when possible, with the Medical Staff President, the immediate Past Medical Staff President, the appropriate Department Chair, or the Credentials Committee chair
- (e) The MEC
- (f) The Board or its chair

10.3.2 A summary suspension is effective immediately. The person or group imposing the suspension shall immediately inform the Chief Executive Officer of the suspension, and he/she shall promptly give Special Notice thereof to the Practitioner.

10.3.3 As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review and consider the need, if any, for a professional review action. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in the Fair Hearing Policy, even if the Practitioner involved attends the meeting, and no procedural requirements shall apply. The



MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the CEO or Board. In the case of a summary suspension imposed by the CEO or Board, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

10.3.4 Not later than fourteen (14) days following the original imposition of the summary suspension, the Practitioner shall be advised by Special Notice of the MEC's determination or, in the case of a summary suspension imposed by the CEO or Board, of the MEC's recommendation as to whether such suspension should be terminated, modified, or sustained, and of the Practitioner's rights, if any, pursuant to the Fair Hearing Policy. A summary suspension that is lifted within fourteen (14) days of its original imposition on the grounds that it was not necessary shall not be deemed an Adverse action for purposes of the Fair Hearing Policy.

#### 10.4 Automatic Suspension.

10.4.1 Imposition of Automatic Suspension. The following events shall result in an automatic suspension or limitation of a Practitioner's Medical Staff appointment and/or Privileges without recourse to the procedural rights set forth in the Fair Hearing Policy.

- (a) Licensure. Action by any federal or state authority suspending or limiting a Practitioner's professional license/certificate shall result in an automatic comparable suspension/limitation on the Practitioner's Privileges. Whenever a Practitioner's license is made subject to probation, the Practitioner's right to practice shall automatically become subject to the same terms of the probation.
- (b) Controlled Substance Authorization. Whenever a Practitioner's federal or state controlled substance registration/certificate is suspended, limited or revoked, the Practitioner shall automatically and correspondingly be divested and/or limited of the right to prescribe medications covered by the certificate as of the time such action becomes effective and through its term. Whenever a Practitioner's state or federal controlled substance registration/certificate is made subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation.
- (c) Federal Healthcare Program. Whenever a Practitioner is suspended from participating in a Federal Healthcare Program, the Practitioner's appointment and Privileges shall be immediately and automatically suspended.
- (d) Professional Liability Insurance Coverage. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect, in whole or in part, the Practitioner's appointment and Privileges shall be automatically suspended or restricted, as applicable, until the matter is resolved and adequate Professional Liability Insurance coverage is restored or the Practitioner's appointment and Privileges are terminated pursuant to §10.5.1(b). The Medical Staff Services shall be provided with a copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the previous insurance cancellation or non-renewal, any limitation on the new policy, and a summary of relevant activities during the period of no coverage. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.
- (e) Failure to Complete Medical Records. Whenever a Practitioner fails to complete medical records as provided for in the Medical Staff Rules & Regulations and/or

applicable policies, the Practitioner's appointment and/or Privileges shall be automatically suspended if consistent with such Rules & Regulations or policies.

- (f) Failure to Comply with Vaccination Policies. If a Practitioner does not comply with applicable vaccination policies and fails to provide proof of compliance with vaccination policies, the Practitioner's appointment and/or privileges shall be automatically suspended until the Practitioner provides proof of compliance. For purposes of this section, the failure of a Practitioner to provide proof of compliance with vaccination policies shall constitute a failure to meet the requirements of this paragraph.

10.4.2 Impact of Automatic Suspension/Limitation. During such period of time when a Practitioner's appointment and/or Privileges are suspended or limited pursuant to §§10.4.1 (a) – (d) or (f) above, he/she may not, as applicable, exercise any appointment Prerogatives or any Privileges at the Hospital, participate in on-call coverage, schedule surgery, otherwise provide professional services within the Hospital for patients, or admit patients under the name of another Practitioner. A Practitioner whose appointment and/or Privileges are suspended or limited pursuant to §10.4.1 (e) is subject to the same limitations except that such Practitioner may:

- (a) Attend an obstetrical patient who has been under his/her active care and management and who comes to term and is admitted to the Hospital.
- (b) Attend to the management of any patient under his/her care whose admission or outpatient procedure was scheduled prior to the effective date of the suspension and which occurs within forty-eight (48) hours of the suspension.

10.4.3 Action Following Imposition. At its next regular meeting after imposition of an automatic suspension, or sooner if the MEC deems it appropriate, the MEC shall convene to determine if further corrective action is necessary in accordance with this Article. The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the Practitioner's appointment and/or Privileges shall result in the automatic reinstatement of such appointment and/or Privileges; provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the Practitioner shall be obligated to provide such information as the Medical Staff Services shall reasonably request to assure that all information in the Practitioner's credentials file is current.

## 10.5 Automatic Termination.

10.5.1 Imposition of Automatic Termination. The following events shall result in an automatic termination of a Practitioner's Medical Staff appointment and Privileges without recourse to the procedural rights contained in the Fair Hearing Policy.

- (a) Licensure. Action by any federal or state authority terminating a Practitioner's professional license/certificate shall result in an automatic termination of the Practitioner's Medical Staff appointment and Privileges.
- (b) Professional Liability Insurance. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect for a period greater than thirty (30) days, the Practitioner's Medical Staff appointment and Privileges shall automatically terminate as of the thirty-first (31<sup>st</sup>) day. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

- (c) Federal Healthcare Program. Whenever a Practitioner is excluded from participating in a Federal Healthcare Program, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.
- (d) Plea of Guilty to Certain Offenses. If a Practitioner pleads guilty or no contest to, or is found guilty of a felony or other serious offense relating to controlled substances, illegal drugs, alcohol, insurance, or health care fraud or abuse, or violence, the Practitioner's Medical Staff appointment and Privileges shall be immediately and automatically terminated; provided, if the behavior which triggered the conviction is based upon the Practitioner's impairment, then the matter shall be referred to the Peer Support Committee for consideration and recommendation to the MEC as to what action should be taken.
- (e) Failure to Pay Dues/Assessments. Failure to pay Medical Staff dues or fines as required within one hundred and twenty (120) days after the date that such dues or fines are due shall result in an automatic termination of the Practitioner's Medical Staff appointment and Privileges if consistent with applicable policy.
- (f) Lapse of Board Certification. Failure to maintain board certification as set forth in §3.6.1 (f) shall result in automatic termination of the Practitioner's appointment and Privileges as set forth in §3.6.1 (f).
- (g) Failure to Comply with Vaccination Policies. If a Practitioner fails to comply with vaccination policies for a period greater than sixty(60) days after automatic suspension pursuant to § 10.4.1 (f), the Practitioner's Medical Staff Appointment and/or Privileges shall automatically terminate as of the sixty-first (61<sup>st</sup>) day. For purposes of this section, the failure of a Practitioner to provide proof of compliance with vaccination policies shall constitute a failure to meet the requirements of this paragraph.

10.6 Continuity of Patient Care. Upon the imposition of a summary suspension, automatic suspension or automatic termination, the Medical Staff President or the applicable Department Chair shall provide for alternative coverage for the affected Practitioner's Hospital patients. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The affected Practitioner shall confer with the substitute Practitioner(s) to the extent necessary to safeguard the patient.

10.7 Sharing of Information. So that there is consistency between the Hospital and Affiliate Hospital(s) regarding corrective action and the status of Medical Staff appointment and privileges considering that the Hospital and the Affiliate Hospital(s) are part of the same Health System, and that the Hospital and the Affiliate Hospital(s) have agreed to share information regarding appointment and/or privileges, the following automatic actions shall occur:

10.7.1 If a Practitioner's appointment and/or privileges are automatically suspended or terminated, in whole or in part, at an Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same action without recourse to the procedural due process provisions set forth in the Fair Hearing Policy.

10.7.2 If a Practitioner's appointment and/or privileges are summarily suspended or if the Practitioner voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such suspension and/or agreement shall automatically and equally apply to the Practitioner's appointment and/or Privileges at this Hospital and shall remain in effect until such time as the Affiliate Hospital(s) renders a final decision or otherwise terminates the process.

10.7.3 If a Practitioner's appointment and/or privileges are terminated, revoked, or limited at an Affiliate Hospital(s), in whole or in part, based on quality of care or professional behavior concerns, the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process provisions set forth in the Fair Hearing Policy, unless otherwise provided in the final decision at the Affiliate Hospital(s).

10.8 Fair Hearing/Appeal Process.

10.8.1 Unless otherwise provided in the Bylaws or Policies, when a Member or Applicant receives notice of an Adverse recommendation of the MEC, the Member/Applicant shall be entitled to a hearing before a hearing officer or a hearing panel appointed by the MEC or Board. If the recommendation of the MEC following such hearing is still Adverse to the Member/Applicant, the Member/Applicant shall then be entitled to an appellate review by the Board before the Board makes a final decision on the matter.

10.8.2 Unless otherwise provided in the Bylaws or Policies, when a Member or Applicant receives notice of an Adverse recommendation or action by the Board, and such decision is not based on a prior Adverse recommendation of the MEC with respect to which the Member/Applicant was entitled to a hearing, the Member/Applicant shall be entitled to a hearing before a hearing officer or a hearing panel appointed by the Board. If the recommendation or action of the Board following such hearing is still Adverse to the affected Member/Applicant, the Member/Applicant shall then be entitled to an appellate review by the Board before the Board makes a final decision on the matter.

10.8.3 Upon receipt of a timely and proper request therefore, a hearing shall be scheduled by the CEO.

10.8.4 The hearing shall be conducted by either (i) a hearing officer, or, (ii) a hearing panel, as determined by whichever body, the MEC or Board, made the Adverse recommendation or took the Adverse action that is the basis for the hearing.

(a) A hearing officer may be a Practitioner, an individual from outside the Hospital, such as an attorney, or other individual qualified to conduct the hearing. The hearing officer is not required to be a Medical Staff Member.

(b) A hearing panel shall consist of not less than three (3) individuals and shall be chosen by the MEC or the Board, whichever body made the Adverse recommendation or took the Adverse action that is the basis for the hearing. The panel members may either be Practitioners or individuals from outside of the Hospital, or a combination thereof, as determined by the MEC or the Board, as appropriate.

10.8.5 The hearing shall be conducted in a manner consistent with the then current requirements of the Health Care Quality Improvement Act, as amended from time to time, and as further detailed in the Fair Hearing Policy.

**ARTICLE XI  
CONFIDENTIALITY, AUTHORIZATIONS, IMMUNITY AND RELEASES**

- 11.1 **Special Definitions.** For purposes of this Article, the following definitions shall apply:
- 11.1.1 "Information" means records of proceedings, minutes, interviews, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications, whether in electronic, written or oral form, relating to any of the subject matter specified in §11.5.
  - 11.1.2 "Representative" means the Hospital Board and any trustee or committee thereof; the Hospital, Chief Executive Officer and other Hospital employees; the Medical Staff organization and any officer or committee thereof; any Practitioner with a Medical Staff appointment and Privileges; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.
  - 11.1.3 "Third Parties" means any individual or organization providing Information to any Representative.
- 11.2 **Authorizations and Conditions.** By submitting an application for Medical Staff appointment or reappointment, or by applying for or exercising Privileges at the Hospital, a Practitioner:
- 11.2.1 Authorizes Representatives and Third Parties, as applicable, to solicit, provide and act upon Information bearing on the Practitioner's professional ability and qualifications.
  - 11.2.2 Authorizes the release of all Information necessary for an evaluation of his/her qualifications for Medical Staff appointment and/or Privileges, and agrees to sign such authorizations as requested by the Hospital.
  - 11.2.3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative or Third Party who acts in accordance with the provisions of this Article.
  - 11.2.4 Acknowledges that the provisions of this Article are express conditions to his/her application for, acceptance of, and continuation of Medical Staff appointment and/or to his/her exercise of Privileges at the Hospital.
- 11.3 **Confidentiality of Information.** Information with respect to any Practitioner submitted, collected or prepared by any Representative of this or any other health care facility or organization or medical staff for the purpose of: evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care; evaluating the qualifications, competence, and performance of a Practitioner or acting upon matters relating to corrective action; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and performed in compliance with the applicable standards of care; or, establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Such Information shall not be disclosed or disseminated to anyone other than a Representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the Information is needed, nor be used in any way except as provided in the Bylaws or as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by/to Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for immediate termination of Medical Staff appointment and Privileges.

- 11.4 Immunity from Liability. Submission of an application for Medical Staff appointment and/or for the exercise of Privileges at the Hospital constitutes a Practitioner's express release of liability of the following:
- 11.4.1 For Action Taken: No Representative or Third Party shall be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.
  - 11.4.2 For Gathering/Providing Information: No Representative or Third Party shall be liable to a Practitioner for damages or other relief by reason of gathering or providing Information, including otherwise confidential or privileged Information, within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing it to be false.
- 11.5 Activities and Information Covered. The confidentiality and immunity provided by this Article applies to Information in connection with this or any other health care facility's or organization's activities including, but not limited to:
- 11.5.1 Applications for appointment and/or Privileges.
  - 11.5.2 Applications for reappointment, addition, modification, or re-grant of Privileges.
  - 11.5.3 Corrective action.
  - 11.5.4 Hearings and appellate reviews.
  - 11.5.5 Performance improvement/quality assessment activities.
  - 11.5.6 Utilization review/management activities.
  - 11.5.7 Claims reviews.
  - 11.5.8 Profiles and profile analysis.
  - 11.5.9 Risk management activities.
  - 11.5.10 Any other Hospital, committee, Department, or Medical Staff activities related to evaluating, monitoring, and maintaining quality and efficient patient care and professional conduct.
- 11.6 Releases. Upon request of the Hospital, each Practitioner shall execute releases necessary to obtain documents and information necessary to evaluate the competency and/or conduct of a Practitioner. Such releases will operate in addition to the provisions of this Article. Execution of such releases shall not be a prerequisite to the effectiveness of this Article.
- 11.7 Cumulative Effect. Provisions in these Medical Staff Bylaws and in the application or other Hospital or Medical Staff forms relating to authorizations, confidentiality of Information, and immunity from liability are in addition to, and not in limitation of, other protections provided by applicable law. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

**ARTICLE XII  
INTERNAL CONFLICT OF INTEREST**

12.1 In General.

In any instance where a Practitioner has or reasonably could be perceived to be biased or to have a conflict of interest in any matter that comes before the Medical Staff, a Department, Section, or committee, the Practitioner shall not participate in the discussion or vote on the matter and shall absent himself/herself from the meeting during that time. The Practitioner may be asked and may answer any questions concerning the conflict before leaving. The Medical Staff officers, Department or committee chair, or Section Chief may routinely inquire, prior to initiating discussion, as to whether any Practitioner has any bias or conflict of interest regarding the matter(s) to be addressed. The existence of a bias or potential conflict of interest on the part of any Practitioner shall be called to the attention of the Medical Staff officers, Department or committee chair, or Section Chief by any Practitioner with knowledge of the conflict.

12.2 Department Chair.

A Department Chair shall have the duty to delegate review of applications for appointment, reappointment, or grant/regrant of Privileges to the Department Vice-Chair if the Department Chair has a conflict of interest with the individual under review which could be reasonably perceived to create bias. The fact that a Department Chair and member(s) of the Department are competitors or partners shall not, in and of itself, constitute a conflict of interest requiring delegation.

**ARTICLE XIII  
ADOPTION AND AMENDMENT**

13.1 Medical Staff Authority. The Medical Staff has the ability to develop and adopt Medical Staff Bylaws, Rules & Regulations and Policies, and amendments thereto, consistent with this Article.

13.2 Adoption/Amendment of Medical Staff Bylaws.

13.2.1 Medical Staff Authority and Responsibility. The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board, Medical Staff Bylaws, and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner reflecting the interests of providing patient care at the generally recognized professional level of quality and efficiency and of maintaining harmony with the Board and community served. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws. All actions of the Medical Staff are subject to the ultimate authority of the Board.

13.2.2 Medical Staff Action. Adoption or amendment of these Bylaws shall require the affirmative vote of a majority of the Active Members in Good Standing cast at a regular or special Medical Staff meeting at which a quorum is present. In the alternative, action may be taken without a meeting by ballot of the Active Members in Good Standing eligible to vote. Ballots must be received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken. The number of responses must be equal to or greater than the number required for a quorum and a majority of the responses must be an affirmative vote. A copy of the proposed documents or amendments must be given, or made available, to each Medical Staff Member entitled to vote thereon with notice of the impending vote at least fifteen (15) days prior to such vote. The results of the Medical Staff's vote shall be forwarded to the Board for its action.

13.2.3 Board Action.

(a) When Favorable to Medical Staff Recommendation. Medical Staff recommendations regarding adoption or amendment of Bylaws are effective upon the affirmative vote of a majority of the members of the Board or as otherwise provided in the Hospital's code of regulations.

(b) When Contrary to or Without a Medical Staff Recommendation. In the event the Medical Staff fails to exercise its responsibility in good faith and in a reasonable and timely manner and after written notice from the Board to such effect, including a reasonable time for response, the Board may take action pursuant to these Bylaws. Should the Medical Staff fail to respond under such circumstances or should the Board disagree with any responses or recommendations from the Medical Staff for adoption or amendment of the Medical Staff Bylaws, the matter shall be referred to an *ad hoc* Joint Conference Committee (as set forth in §2.1.8 of the Credentials Policy) for consideration of the recommendations of the Board and the Medical Staff regarding the proposed adoption or amendments to the Bylaws prior to final action by the Board.

13.2.4 Joint Conference Committee Action. The Joint Conference Committee shall make a recommendation to the Board within thirty (30) days of receipt of the proposed adoption of, or amendment(s) to, the Bylaws. At its next regularly scheduled meeting after receipt of a recommendation from the Joint Conference Committee, the Board shall take final action with respect to the adoption or amendment(s) under consideration. Such action by the Board may include ratifying or modifying, in whole or in part, the recommendation of the Joint Conference Committee to remain in compliance with law and accreditation



requirements. Should there be a tie among the Joint Conference Committee members with respect to the issues being considered, the chair of the Board shall be called upon to cast a vote on the issue under consideration.

- 13.2.5 Technical Changes. The MEC shall be permitted to approve minor, non-substantive, technical or typographical changes to the Bylaws as necessary without undertaking a full review and approval of the Medical Staff.
  - 13.2.6 Review. The Bylaws shall be reviewed on a biennial basis or more often if needed to bring them into compliance with current changes in the law or accreditation requirements.
  - 13.2.7 Distribution. Whenever significant changes are made to the Bylaws, a revised text of the written materials shall be provided, or made available, to the Medical Staff and, as applicable, other individuals with Privileges.
- 13.3 Adoption and Amendment of Medical Staff Policies and Rules and Regulations. Subject to subsections 13.3.1 – 13.3.4 below, the Medical Staff delegates to the Medical Executive Committee the responsibility to adopt and amend such Policies and Rules & Regulations as may be necessary to implement the general principles set forth in these Bylaws and for the proper conduct of the Medical Staff. Such Policies and Rules and Regulations may be adopted or amended by a majority vote of the MEC members in Good Standing and entitled to vote thereon. Adoption or amendment of Medical Staff Policies and Rules & Regulations shall become effective when approved by the Board.
- 13.3.1 If the MEC proposes to adopt a Rule or Regulation, or an amendment thereto, it shall first communicate the proposal to the Medical Staff.
  - 13.3.2 When the MEC adopts a Medical Staff Policy, or an amendment thereto, the MEC shall communicate such Policy, or amendment, to the Medical Staff.
  - 13.3.3 In the event that at least ten percent (10%) of the voting members of the Medical Staff propose, as reflected by a signed petition, to adopt a Rule, Regulation, or Policy, or an amendment thereto, the Medical Staff shall first communicate its proposal to the MEC.
  - 13.3.4 In the event of a documented need for an urgent amendment to a Rule or Regulation necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve such urgent amendment without prior notice to the Medical Staff. In such event, the Medical Staff shall thereafter be immediately notified by the MEC and shall be provided with the opportunity for retrospective review of, and comment on, the provisional amendment. If the Medical Staff agrees with the MEC's action, the provisional amendment shall stand. If the Medical Staff disagrees with the MEC's action, a meeting of the MEC and Medical Staff shall be held and, if necessary, a revised amendment shall be submitted to the Board for action.
- 13.4 Department Rules & Regulations. Subject to the approval of the MEC and the Board, each Department may formulate its own written policies, if any, as needed for the conduct of its affairs and the discharge of its responsibilities.
- 13.5 Conflict Between Documents. The Medical Staff Bylaws, Policies and Rules & Regulations, the Hospital's Code of Regulations and applicable Hospital policies shall be compatible with each other and compliant with law and regulation. In the event of a conflict between the Hospital's code of regulations and the Medical Staff Bylaws, Rules & Regulations or Medical Staff Policies, the Hospital's code of regulations shall control; provided, however, that such conflict shall then be referred to the Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved. In the event of a conflict between the Medical Staff Bylaws and the Rules

& Regulations or Medical Staff Policies, the Medical Staff Bylaws shall control; provided, however, that a meeting of the Medical Staff and MEC shall be called as soon as is practical after learning of the conflict in order to resolve it.

- 13.6 Member Action. Any Active Member may raise a challenge to the Rules & Regulations or any Policy established by the MEC and approved by the Board. In order to raise such challenge, the Active Member must submit to the MEC a petition signed by not less than ten percent (10%) of the Active Members of the Medical Staff. Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such Policy, Rule or Regulation; and/or (b) schedule a meeting with the petitioners to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioner(s), the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.
- 13.7 Medical Staff/MEC Conflict Resolution. In the event of a conflict between the Medical Staff and the MEC, a special meeting of the Medical Staff and MEC shall be convened to discuss issues of concern and resolution therefore. In the event that the issue cannot be resolved to the mutual satisfaction of both parties, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

**ARTICLE XIV  
CERTIFICATION OF ADOPTION & APPROVAL**

Proposed revisions to these Mount Carmel Health System Medical Staff Bylaws were presented to the Mount Carmel Health, Mount Carmel New Albany, and Mount Carmel St. Ann's medical staffs for recommended approval on two separate occasions in August 2021 and November 2021. The number of votes required to achieve a quorum was not met in either instance; therefore, the proposed revisions were not sent to the Mount Carmel Health System Board of Trustees for final approval.

A Joint Conference Committee was convened and met on December 15, 2021. With minor revisions, the Joint Conference Committee recommended that the Mount Carmel Health System Board of Trustees approve the proposed revisions to these Mount Carmel Health System Medical Staff Bylaws.

**APPROVED** by the Mount Carmel Health System Board of Trustees on January 19, 2022.

  
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Jordan Hansell, Chair  
Mount Carmel Health System Board of Trustees