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1. DEFINITIONS/CONSTRUCTION OF TERMS AND HEADINGS

1.1. DEFINITIONS

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

Administration: The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO); Chief Medical Officer (CMO); Vice President Human Resources; and Associate Chief Nursing Officer (ACNO); and Associate Administrator

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

Adverse Action: As provided in these Bylaws, means an action to restrict, suspend, revoke, deny or not renew a Practitioner’s Medical Staff membership and/or clinical privileges, that is taken or made in the course of a professional review activity and is based on an evaluation of the Practitioner’s clinical competence or professional conduct. An adverse action shall entitle the individual to the procedural rights described in Article Seven, except as provided in these Bylaws. This term is synonymous with “professional review action”.

Advanced Practice Professional (APP)/Allied Health Professional (AHP): An individual, other than those defined under “Practitioner,” who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. APPs also known as AHP’s are designated by the Board to be credentialed through the Medical Staff system and are granted practice parameters as either a dependent or independent healthcare professional as defined in these Bylaws. APPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and
advanced registered nurse practitioners (APRN)\(^1\)

**Adverse Action:** As provided in these Bylaws, means an action to restrict, suspend, revoke, deny or not renew a Practitioner’s Medical Staff membership and/or clinical privileges, that is taken or made in the course of a professional review activity and is based on an evaluation of the Practitioner’s clinical competence or professional conduct. An adverse action shall entitle the individual to the procedural rights described in Article Seven, except as provided in these Bylaws. This term is synonymous with “professional review action”.

**Applicant:** An individual, as defined by these Bylaws, who has submitted a Complete Application for appointment, reappointment or clinical privileges.

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

**Board Certification Candidate:** A Practitioner who has successfully completed a residency or fellowship program for the Practitioner’s specialty within the last five years and who is able to provide proof that he/she has applied for and been accepted to take the exam for certification, or has successfully completed the written portion of the exam and is a current candidate to take an oral portion of the testing, or submit cases for review, or otherwise complete the certification requirements. A Practitioner shall no longer be deemed a Board Certification Candidate if the five year time limit has been exceeded without successful completion of Board Certification, or the Practitioner has exhausted the permitted number of attempts at the exam without success. Acceptable certification boards are defined under “Board Certification” in this section of the Bylaws.

**Board of Directors:** The individuals elected by the shareholders for the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital\(^2\) and are the governing body of the Corporation (or Partnership), sometimes herein

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\(^1\) 42 C.F.R. §482.12(a)(1)
\(^2\) 42 C.F.R. §482.12
referred to as the “Directors.”

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

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

Certification: The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.\(^3\)

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

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

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department/Section Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.\(^4\) Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Conflict Management: The identification and use of techniques to effectively manage interpersonal, intra- and inter-group, and organizational conflicts. It requires impartiality, and use of negotiating and listening skills.

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

Corporation (or Partnership): The legal owner of the Hospital, Wesley Medical Center LLC d/b/a Wesley Medical Center

CPCS: The Clinical Patient Care System, used to electronically document patient care (e-Clinical Works and Meditech)

Criminal Action: Conviction, or a plea of guilty or no contest pertaining to any felony,

\(^3\) HCA, Ethics & Compliance Policy QM.002
\(^4\) MS.06.01.03, MS.06.01.07, MS.08.01.03
involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or
insurance or health care fraud or abuse; or (iv) violence against another. Any conviction
of a misdemeanor involving items i, ii, iii, iv or v will be reviewed on a case by case basis.

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

Days: Calendar days, unless otherwise noted.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental
medicine degree from a dentistry program accredited by the Commission on Dental
Accreditation (CODA) and has a current, unrestricted license to practice dentistry.

Dependent Healthcare Professional: An individual who is permitted both by law and by
the Hospital to provide patient care services under the direction or supervision of an
independent practitioner, within the scope of the individual’s license or certification and
in accordance with a Hospital-approved scope of practice. 5

Department: A clinical grouping of members of the Medical Staff in accordance with
their specialty or major practice interest, as specified in these Bylaws. (Emergency; Pathology & Radiology)

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

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

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

Federal Health Care Program: Any plan or program that provides health benefits,
whether directly, through insurance, or otherwise, which is funded directly, in whole or
in part, by the United States Government or a State health care program (with the
exception of the Federal Employees Health Benefits Program). 6 The most significant
Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee
Program (FEP)/Tricare and the Veterans programs. 7

Focused Professional Practice Evaluation (FPPE): Focused professional practice
evaluation is a Medical Staff Organization-defined process whereby the
privilege/procedure-specific competence of a practitioner who does not have documented
evidence of competently performing the requested privilege at Wesley Medical Center
(WMC) is evaluated. This process may also be used when a question arises regarding a
currently privileged practitioner’s ability to provide safe, high-quality patient care. See
Professional Practice Evaluation policy

Good Standing: The term “good standing” means a practitioner who, during the current
term of appointment, has maintained all qualifications for Medical Staff membership, the
assigned staff category, and been granted clinical privileges granted to the individual, and
has met meeting attendance, on-call and other participation requirements, is not in arrears
in dues payment or the completion of medical records, and is not currently subject of

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5 HCA, Ethics & Compliance Policy QM.002; 42 C.F.R. §482.12(c)(2)
6 Section 1128B(f) of the Social Security Act
7 HCA, Ethics & Compliance Policy QM.002
professional review action; and has not received a limitation, suspension, or restriction of Medical Staff membership or privileges.

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

**Graduate Medical Education (GME):** the second phase of medical education which prepares physicians for practice in a medical specialty. GME focuses on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty.

**GSA List:** The General Service Administration’s List of Parties Excluded from Federal Programs. 8

**HCQIA:** The Health Care Quality Improvement Act of 1986, 42 U.S.C.S. §11101 et seq.

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

**Hospital:** Wesley Medical Center, LLC d/b/a Wesley Medical Center – 550 N. Hillside, Wichita, Kansas 67214  As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

**Independent Healthcare Professional:** An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual’s license and in accordance with individually granted clinical privileges. Also referred to as a “Licensed Independent Practitioner”. 9

**Ineligible Person:** Any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.10

**License:** An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.11

**License Status:** Indicates the status of the practitioner’s license, which is issued by the State licensure board. The categories defined by the State board are:12

- active—full and unrestricted license to practice
- inactive—practitioner is not practicing, but reserves the right to activate their license in the future
- expired—no longer valid for use
- revoked—disciplinary action prohibits practice
- restricted—board imposed limitation on practice

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8 HCA, Ethics & Compliance Policy QM.002
9 HCA, Ethics & Compliance Policy QM.002; 42 C.F.R. §482.12(c)(1); 42 C.F.R. §482.12(c)(4)
10 HCA, Ethics & Compliance Policy QM.002
11 HCA, Ethics & Compliance Policy QM.002
Exempt – practitioner is not actively engaged in practice and does not hold himself as such but may serve as a coroner, as a paid employee of a local health department, or may practice as a charitable health care provider for an indigent health care clinic, or may perform administrative functions.

Federal Active – practitioners in the course of employment or active duty in the United States government or any of its Department/Sections, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102.

Military active-practitioner – is a member of the military

**Licensure:** A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.\(^{13}\)

**Licensed Independent Practitioner (LIP):** An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual’s license and in accordance with individually granted clinical privileges. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).\(^{14}\)

**Medical Staff:** The Medical Staff is the term referring to the Practitioners designated by the Board to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM). The Medical Staff is an integral part of the Hospital and is not a separate legal entity.\(^{15}\)

**Medical Staff President:** A Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as President of the Medical Staff of this Hospital. The Medical Staff President shall be a doctor of medicine or osteopathy who has been on the Active Medical Staff for at least two (2) years, unless waived in unusual circumstances and remain a member in good standing during his/her term of office.

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

**Medical Staff, Organized:** The Organized Medical Staff is a formally organized body of those individuals who, as a group, are responsible for establishing the bylaws and rules and regulations, and policies for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members. The Organized Medical Staff is limited to Practitioners who are Medical Staff Members in the Active category of membership and

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\(^{13}\) HCA, Ethics & Compliance Policy QM.002

\(^{14}\) 42 C.F.R. §482.12(a)(1); 42 C.F.R. §482.12(c)(1)

\(^{15}\) 42 C.F.R. §482.12(a)(1)
have therefore been granted the rights to vote, to be a Member of a Medical Staff committee, and to hold office in the Organized Medical Staff.

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

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

**Membership:** The approval granted by the Board to a qualified Practitioner to be a Member of the Medical Staff or is recognized as an APP at the Hospital.

**Moonlighting Resident:** A current resident in an approved program who has received approval from the residency program director to apply to provide evaluation and treatment of patients in approved clinical areas, under observation of a sponsoring physician.

**OIG Sanction Report:** The HHS/OIG List of Excluded Individuals/Entities. ¹⁶

**Ongoing Professional Practice Evaluation (OPPE):** Ongoing professional practice evaluation is the continuous evaluation of the practitioner’s professional performance, rather than an episodic evaluation. It is intended to identify and resolve potential performance issues as soon as possible, as well as foster a more efficient, evidence-based privilege renewal process. See Professional Practice Evaluation policy

**Oromaxillofacial Surgeon Qualified:** An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA). ¹⁷

**Peer:** An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications. ¹⁸

**Peer Review:** The concurrent or retrospective review of an individual’s performance of clinical professional activities by peer(s) through formally adopted written procedures consistent with the Kansas peer review statute and/or the Kansas risk management statutes. With reference to Practitioners and Advanced Practice Professionals, written procedures for peer review are part of these Bylaws.

**Physician:** A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. [42 U.S.C. §1395x]

**Podiatrist:** A doctor of podiatric medicine legally authorized to practice podiatry by the State in which he performs such function or action.

**Practice Parameters:** Specifically designated patient care services as are under the control, responsibility and supervision of the employing or consulting member of the medical staff. Authorization granted by the Board to an APP to provide direct patient care services in the Hospital under a defined degree of supervision.

**Practitioner/Licensed Independent Practitioner (LIP):** Individuals who provide direct

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¹⁶ HCA, Ethics & Compliance Policy QM.002
¹⁷ Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH), Glossary
¹⁸ MS.07.01.03
patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).

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

Proctor/Proctoring: Clinical proctoring is an objective evaluation of a Practitioner’s actual clinical competence by a monitor or proctor as determined by practitioner’s clinical service/department and approved by the MEC.

Professional Practice Evaluations: See Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation

Professional Review Action: As provided in these Bylaws, means an action to reduce, restrict, suspend, revoke, deny or not renew a Practitioner’s Medical Staff membership and/or clinical privileges, that is taken or made in the course of a professional review activity and is based on an evaluation of the Practitioner’s clinical competence or professional conduct. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these bylaws. This term is synonymous with “adverse action”.

Professional Review Activity: A formal investigation or other activity of a professional review body with respect to a Member or Practitioner applicant to determine whether the Member or Practitioner applicant may have clinical privileges or Medical Staff membership; to determine the scope or conditions on such privileges or membership, or to change or modify such privileges or membership.

Professional Review Body: A committee, subcommittee or other body that engages in professional review activities for the purpose of furthering the delivery of quality healthcare. The designation of “Professional Review Body” includes but is not limited to any committee or subcommittee constituted to perform peer review activities as a component of its responsibilities, including the Board of Trustees.

Qualified Medical Person or Personnel: In addition to a physician, Qualified Medical Persons may perform a Medical Screening Examination. Individuals in the following professional categories who have demonstrated current competence in the performance of Medical Screening Examinations, and who are functioning within the scope of his or her license and policies of the Hospital, have been approved by the Board as Qualified Medical Personnel: Registered Nurse in Perinatal Services and newborn areas; an APRN or physician assistant for low acuity Emergency Department/Section patients per their

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19 42 C.F.R. §482.12(a)(1); 42 C.F.R. §482.12(c)(1)
20 42 C.F.R. §482.12(a)(6); MS.06.01.07
21 MS.06.01.07
protocol; a registered nurse or an APRN/PA for ground or air transport

Referring Physician: Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.22

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.23

Reportable Incident – an act by a health care provider which: (1) is or may be below the applicable standard of care and causes injury or has a reasonable probability of causing injury to a patient; or (2) may be grounds for disciplinary action by the appropriate licensing agency. Peer review committees shall determine in each case the elements of a reportable incident based upon accepted medical knowledge. Peer review committees may refer to, but shall not be bound by, written interpretative guidelines

Residency Program – the unit of specialty education, comprising a series of graduated learning experiences in GME, designed to conform to the program requirements of a particular specialty.

Resident – a physician at any level of GME in a program accredited by the Accreditation Council of Graduate Medical Education (ACGME) or by the American Osteopathic Association.

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

Section/Service: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws. Anesthesia; Family Medicine; Internal Medicine; Cardiology; Ob/Gyn; Orthopedics; Pediatrics; Surgery

Sponsoring Institution – the institution that assumes the ultimate responsibility for a program of GME (e.g., the University of Kansas School of Medicine – Wichita sponsors all residency programs at Wesley Medical Center).

Staff: Unless otherwise specifically stated, the Medical Staff of this Hospital.

Standard of Care – a practitioner must use such reasonable care as the patient’s condition may require. The standard is the care, skill and diligence used by members of the practitioner’s profession and specialty at Wesley Medical Center, and in this or similar communities, under like circumstances.


22 HCA, Ethics & Compliance Policy QM.002
23 HCA, Ethics & Compliance Policy QM.002
Definition of the Federation of State Medical Boards

Teaching Staff – physicians of the Wesley Medical Center Medical Staff who supervise the clinical activities of residents and medical students.

Telemedicine: Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.

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

1.2. CONSTRUCTION OF TERMS AND HEADINGS

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

2. NAME, PURPOSES & RESPONSIBILITIES

2.1. NAME

The name of the Medical Staff shall be the “Medical and Dental Staff of Wesley Medical Center, Wichita, Kansas, herein commonly designated as The Medical Staff.

2.2. PURPOSES AND RESPONSIBILITIES

The purpose and responsibilities of the medical staff are:

2.2.1. To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and functions of the Medical Staff.

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

24 Definition of the Federation of State Medical Boards
25 MS.13.01.01 – MS.13.01.03
26 Joint Commission Comprehensive Accreditation Manual for Hospitals
27 MS.01.01.01; LD.01.05.01, 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3), 42 C.F.R. §482.12(a)(3)
2.2.3. To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital.\textsuperscript{28}

2.2.4. To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance.\textsuperscript{29}

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

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

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

2.2.8. To provide a means for communication and conflict management with regard to issues of mutual concern to the Staff, Administration, and Board;\textsuperscript{30}

2.2.9. To participate in identifying community health needs and establishing appropriate institutional goals;\textsuperscript{31}

2.2.10. To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review.\textsuperscript{32}

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

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

2.2.13. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.\textsuperscript{33}

2.2.14. To work jointly with the Medical Center, the University of Kansas School of Medicine – Wichita, and the Wichita Center for Graduate Medical Education to define the rules, regulations, and policies which specify the process for supervision of residents in carrying out their patient care responsibilities.

2.2.15. To participate in, and monitor the Medical Center's medical education and training programs;

2.2.16. To participate in the Medical Center's long-range planning activity, to assist in

\textsuperscript{28} LD.04.03.07
\textsuperscript{29} MS.01.01.01; LD.01.05.01 , 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3)
\textsuperscript{30} MS.01.01.01, MS.03.01.03, MS.04.01.01; LD.03.04.01
\textsuperscript{31} LD.02.01.01LD.04.03.01; LD.04.03.01
\textsuperscript{32} 42 C.F.R. §482.12(a)(5), MS.05.01.01, MS.08.01.01; MS.08.01.03; MS.09.01.01
\textsuperscript{33} LD.04.01.01; 42 C.F.R. §482.11(a)
identifying community health needs and to work jointly with the Board of Trustees in developing and implementing appropriate institutional policies and programs to meet those needs;

2.3. ORGANIZED HEALTH CARE ARRANGEMENT; HIPAA COMPLIANCE

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

3. APPOINTMENT/REAPPOINTMENT

3.1. NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS

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

If a practitioner seeking membership and privileges has had no documented clinical experience for more than two (2) years, they will not be eligible to make such application until documentation is presented that shows they have successfully completed a clinical practice re-entry program.

3.1.1. Patients may be admitted to the Hospital only on the orders of Active Physician members of the Medical Staff and Podiatrists approved for admitting privileges. All Hospital patients must be under the care of a Member of the Medical Staff or under the care of a practitioner who shall be directly under the supervision of a
Member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges.\(^{36}\)

3.1.1.1. Patients admitted by licensed independent practitioners who are not physicians (DDS, DMD, DPM) shall be under the care of a physician with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner.\(^{37}\)

Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual’s Staff category or as are afforded to APPs when practice parameters are granted to an individual in this category. For purposes of these Bylaws, “membership in” is used synonymously with “appointment to” the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws.\(^{38}\) The Hospital-specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws,\(^{39}\) and has been approved and implemented by the Medical Staff and the Board.\(^{40}\) All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations.\(^{41}\) Only those individuals possessing all of the following qualifications shall be eligible for appointment to the Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:\(^{42}\)

Medical Staff Member is neither an employee nor an independent contractor of the Hospital unless such relationship is separately established by contract. In the event of any conflict between such contract and these Bylaws, the language in the contract shall apply.

### 3.1.2. LICENSURE

The applicant must possess a current, active (as defined in these Bylaws) license in the State of Kansas for the practice of medicine, dentistry, podiatry or as an Advanced Practice Professional. If the applicant is an active duty military practitioner, and will be practicing exclusively within the scope of military duties

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\(^{36}\) 42 C.F.R. §482.12(a)(5), Interpretive Guidelines  
\(^{37}\) 42 C.F.R. §482.12(c)(4); MS.03.01.03  
\(^{38}\) 42 C.F.R. §482.12(a)(1)  
\(^{39}\) MS.01.01.01  
\(^{40}\) MS.01.01.01  
\(^{41}\) MS.01.01.01, MS.01.01.03, MS.06.01.07, MS.08.01.03  
\(^{42}\) MS.06.01.03, MS.06.01.07, MS.08.01.03  
18
for patients who are members of the armed forces or their dependents, then licensure from any State shall be accepted. If the applicant is a telemedicine provider located in a different State, the applicant must also possess licensure in that State. The applicant shall also be required to provide information related to any current or past licensure as a healthcare professional in any other States.

3.1.3. CONTROLLED SUBSTANCE REGISTRATION

To have prescribing privileges for controlled substances, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration with the applicant’s in-state address for the State of Kansas. If the applicant is an active duty military practitioner, and will be prescribing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then DEA registration with an address from any State shall be accepted. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant.

3.1.4. PROFESSIONAL EDUCATION AND TRAINING

The applicant must have graduated from a School of Medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine, or a School of Dentistry accredited by the Commission on Accreditation of the American Dental Association, or a School of Podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or other accredited school appropriate to his or her profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school. An applicant Practitioner must also have successfully completed a residency program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) for allopathic physicians or AOA for osteopathic physicians, or that is accredited by the American Dental Association for dentists, or that is accredited by the Council on Podiatric Medical Education for podiatrists, and the residency must be in the field of specialty for which the Practitioner requests clinical privileges. Unless the applicant has graduated from a residency or fellowship program within 12 months of submitting an application, the applicant shall document his/her participation in continuing education as related to the clinical privileges requested. Participation in continuing education shall be considered when making decisions about clinical privileges.

3.1.5. CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical

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43 §482.26(c)(1)
44 MS.06.01.07, 42 C.F.R. §482.11(c), 42 C.F.R. §482.22(c)(4)
45 MS.06.01.07
46 MS.06.01.03, 42 C.F.R. §482.12(a)(6), 42 C.F.R. §482.22(c)(4)
47 MS.12.01.01
Executive Committee and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital.\textsuperscript{48} Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Department/Section Chairperson(s).\textsuperscript{49}

3.1.6. BOARD CERTIFICATION

Physician specialty board certification programs accepted by the Hospital are those of the approved Member Boards of American Board of Medical Specialties (ABMS), or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, the board certification program accepted by the Hospital is the American Board of Podiatric Surgery (ABPS) and for dentists the board certification program accepted by the Hospital is the American Board of Oral/Maxillofacial Surgeons (ABOMS).

Failure to obtain board certification within the time frame specified by each specialty board, but in no event more than five (5) years from the date of completion of their last accredited training, shall result in automatic suspension from membership and privileges, and may lead to initiation of Corrective Action. Physicians who do not meet these requirements shall not be eligible to receive an application for medical staff membership and clinical privileges.

Subspecialty certification is not required for appointment to the medical staff, but may be considered for privileges by the clinical section.

Medical Staff Members who were members of the medical staff as of September 1985 were not required to meet the Board Certification requirements, as long as the staff member remains a member of the Wesley Medical Staff.

Maintenance of certification is required for continued membership on the Medical Staff. Those physicians who were on the Medical Staff effective January 8, 2009 are encouraged to recertify, but shall not be required for reappointment to the Medical Staff.

The Board of Trustees, upon recommendation of the Medical Staff may give special consideration for Staff privileges to practitioners who are deemed well qualified, but do not meet the criteria of (a) and (b) above. Special consideration for membership should include whether or not the practitioner provides a special service to the hospital and/or community which is unique and is not available to patients through any other medical staff member. In making this determination, specialty board certification or current qualification as defined by the American Board of Medical Specialties or the American Osteopathic Association, or the

\textsuperscript{48} MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.12(a)(6), 42 C.F.R. §482.22(c)(4)

\textsuperscript{49} MS.06.01.03, MS.06.01.07, 42 C.F.R. §482.12(a)(6)
American Dental Association is an excellent benchmark, although not conclusive proof, in determining a practitioner's qualifications for membership and delineation of clinical privileges.

3.1.7. CONDUCT/BEHAVIOR

The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Division and Department/Section Chairperson(s).

3.1.8. PROFESSIONAL ETHICS AND CHARACTER

By virtue of applying for medical staff membership or clinical privileges, and agreeing to abide by the medical staff bylaws, rules/regulations and policies of the Medical Staff and the Medical Center, the applicant shall be bound to adherence to the code of ethics of his/her professional discipline (e.g., the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant’s practice if it is not listed). The applicant shall also agree to abide by applicable provisions of the Code of Conduct of HCA, and the code of ethical business and professional behavior of this Hospital.\(^\text{50}\)

3.1.9. HEALTH STATUS/ABILITY TO PERFORM

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

3.1.10. COMMUNICATION SKILLS

The applicant shall possess an ability to communicate in English in an
understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients’ medical records, shall be recorded in a legible fashion, in English.

3.1.11. PROFESSIONAL LIABILITY INSURANCE

The applicant shall maintain professional liability insurance coverage through an insurance carrier authorized by the State of Kansas as a licensed provider of professional malpractice insurance, for the clinical privileges requested with limits of at least $1 million for each claim * and $3 million * in aggregate, as a qualification for initial granting of clinical privileges and to cover the term of the individual’s clinical privileges (e.g., “claims-made” coverage).  

*Excess coverage (above basic primary), including amounts provided by the State of Kansas through the Health Care Stabilization Fund, in an amount to equal $1 million for each claim and $3 million in aggregate

3.1.12. ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person, as defined in these bylaws, during the term of an appointment or granting of clinical privileges.

3.1.13. CRIMINAL ACTIONS

No individual shall be eligible for or continue to hold medical staff membership or clinical privileges when the individual has a conviction, or a plea of guilty or no contest pertaining to any felony within the previous seven (7) years involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence against another, or (v) related to the practice of a health care profession and/or the safety of patients and staff, even if not yet excluded, debarred, or otherwise declared Ineligible. Any conviction of a misdemeanor involving items i,ii,iii,iv or v will be reviewed on a case by case basis by the MEC.

3.2. HOSPITAL NEED AND ABILITY TO ACCOMMODATE

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

3.2.1. AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested

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51 HCII recommended insurance requirements
privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.\footnote{MS.06.01.01
MS.06.01.03, MS.06.01.07, MS.08.01.03
42 C.F.R. §482.12(a)(7)
LD.04.01.01
23}

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

3.2.3. MEDICAL STAFF DEVELOPMENT PLAN
The Board may decline to accept applications based on the requirements or limitations in the Hospital’s Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served.\footnote{53}

3.2.4. EFFECTS OF DECLINATION
Refusal to accept or review requests for Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this section, shall not constitute a denial of Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

3.3. EFFECTS OF OTHER AFFILIATIONS
No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a Member of any professional organization, is certified by any board, or has/had staff membership or clinical privileges in another hospital or health care organization.\footnote{54}

3.4. NONDISCRIMINATION
No person shall be denied appointment or clinical privileges on the basis of race, creed, color, religion, gender, sexual orientation, gender identity/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national or ethnic origin.\footnote{55}

3.5. BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES
By submitting an application for Staff membership and/or a request for clinical

\footnote{MS.06.01.01
MS.06.01.03, MS.06.01.07, MS.08.01.03
42 C.F.R. §482.12(a)(7)
LD.04.01.01
23}
privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

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

3.5.2. Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a Member in good standing of the Medical Staff with equivalent training and privileges (as determined by the appropriate Department/Section Chairperson, Medical Staff President or Medical Executive Committee), and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff;

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

3.5.4. Abide by all local, State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant’s professional practice;

3.5.5. Members of the Provisional and Active Staffs are not required to attend meetings, except as provided under Section 11.4.2.

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

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

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

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

3.5.10. Participate in continuing education to maintain clinical skills and current competence.57

3.5.11. Notify and update the Medical Staff and Hospital immediately [“immediately”

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56 MS.03.01.01
57 MS.12.01.01
24
defined as within one business day of being notified of a change] upon a change in any qualifications for membership or clinical privileges, as listed in Article Three of these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person);

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

3.5.13. Prepare and complete the medical and other required records for all patients he/she admits or in any way provides care to in the Medical Center facilities in accordance with these Bylaws and related manuals;

3.6. TERMS OF APPOINTMENT

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

3.7. CREDENTIALS VERIFICATION

3.7.1. REQUESTS FOR CONSIDERATION AND RECREDENTIALING REQUEST FOR CONSIDERATION

A separate credentials record shall be maintained for each potential applicant for Staff membership or clinical privileges. Each Request for Consideration (RFC) or Recredentialing Request for Consideration (R-RFC) for Staff appointment, reappointment, and/or clinical privileges shall be in a prescribed format, and signed by the applicant.

When an individual seeks to apply for initial appointment he/she shall be asked to complete a RFC. The completed RFC shall be submitted to the office of the Medical Provider Resources (MPR). Upon such notification, it is the applicant’s obligation to obtain the required information. When collection and verification is accomplished, MPR shall transmit the RFC and all supporting materials to the Medical Center in which the applicant seeks privileges. The Medical Center will then transmit the RFC to the HCA Credentials Processing Center (CPC) to determine whether the individual is eligible to apply. Once this determination is made by the CPC, they will notify the Medical Center.

Prior to expiration of the current term of membership or clinical privileges for an individual who is a Member of the Medical Staff or who currently holds clinical privileges, the individual should be notified of the impending expiration and will be asked to complete a R-RFC. The completed R-RFC shall be submitted to the

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58 MS.06.01.07
59 MS.06.01.07
60 42 C.F.R. §482.22(a)(2), Guidance to Surveyors
office of MPR. The MPR designee shall collect or verify, licensure and other qualification evidence submitted and promptly notify the applicant of any problems in obtaining the information required. When a completed R-RFC is received from MPR, the R-RFC will be forwarded to the Medical Center and the Medical Center will forward it to the CPC to determine whether the individual is eligible to reapply. Once this determination is made by the CPC, they will notify the Medical Center.

3.7.2. BURDEN ON APPLICANT TO PROVIDE A COMPLETE APPLICATION

The potential applicant or applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities is submitted directly to MPR/the HCA Credentials Processing Center by such sources. The MPR/HCA Credentials Processing Center (CPC) shall not have any obligation to process any RFC or R-RFC unless it is complete, as defined by MPR/CPC policies, and after a time limit defined in MPR/CPC policies, determine that there has been failure to comply and end efforts to process the RFC or R-RFC. Only after a completed RFC or R-RFC has been received and all information verified as specified by MPR/CPC policies, and the individual has been deemed eligible to apply, shall the MPR/CPC submit the information to the Hospital as an application. The Hospital shall analyze the information and determine whether additional information or investigation is needed to resolve any doubts, concerns, or gaps in the information. The applicant shall provide accurate, up-to-date information, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted. Any Medical Staff committee or the Board may request that the applicant appear for an interview with regard to the application. The Medical Staff Services shall notify the applicant by special notice of the specific information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. Failure to provide a complete application, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Services shall provide special notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. The completed application shall include, without limitation:

3.7.2.1. Identifying information, including full name, social security
number, date of birth, any aliases, and addresses of office & residence, government issued photo identification, and any other information required to verify identification or background.

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

3.7.2.3. For a new applicant, written permission for a background check, and completion of the background check.

3.7.2.4. Evidence of current licensure in the State of Kansas and information from the applicant regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction.\(^61\)

3.7.2.5. For applicants requesting medication prescribing privileges, evidence of a Federal DEA listing an in-state address.

3.7.2.6. For a new applicant, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate.\(^62\)

3.7.2.7. For applicants for appointment who are not newly graduated from residency or fellowship program within the last year, and for applicants for reappointments or renewal of clinical privileges, the applicant’s participation in continuing education, specifically as related to the clinical privileges requested.\(^63\)

3.7.2.8. The names of at least two peers who will provide a written evaluation of the applicant’s medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the clinical privileges requested. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal.\(^64\)

3.7.2.9. Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;

3.7.2.10. Information regarding all current healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;\(^65\)

3.7.2.11. Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional

\(^{61}\) MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(2), Guidance to Surveyors, HCA Requirement
\(^{62}\) MS.06.01.03, MS.06.01.07, MS.08.01.03, Intent, 42 C.F.R. §482.22(a)(2)
\(^{63}\) MS.12.01.01
\(^{64}\) MS.06.01.03, MS.06.01.07, MS.08.01.03, MS.07.01.03, 42 C.F.R. §482.22(a)(2)
\(^{65}\) MS.06.01.03
3.7.2.12. Medicare Provider NPI for the individual provider (e.g., not a NPI for a group practice);

3.7.2.13. Information as to any current, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;\(^66\)

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

3.7.2.14.1. Whether the applicant’s professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;\(^67\)

3.7.2.14.2. Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital or other healthcare facility;\(^68\)

3.7.2.14.3. Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,\(^69\)

3.7.2.14.4. Whether the applicant has ever been convicted of or pleaded no contest to a criminal action, as defined in these Bylaws, or whether any such action is pending.

3.7.2.15. A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.1.9;\(^70\)

3.7.2.16. Evidence that the applicant has complied with the health screening and immunization requirements of the Hospital.

3.7.2.17. A statement from the applicant that he/she has received the current Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly adopted;\(^71\)

3.7.2.18. A pledge from the applicant to provide continuous care to his/her

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\(^{66}\) HCA, Ethics & Compliance Policy QM.002

\(^{67}\) MS.06.01.07

\(^{68}\) MS.06.01.07

\(^{69}\) MS.06.01.07

\(^{70}\) MS.06.01.03, 42 C.F.R. §482.22(c)(4)

\(^{71}\) LD.03.04.01

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3.7.2.19. A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant’s health status as required by Section 3.1.9, and for a new applicant a permission to conduct a background check, and a statement providing absolute immunity and release from civil liability for all individuals requesting or providing information relative to the applicant’s professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.

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

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

3.7.2.22. All physicians and other practitioners shall submit a signed Physician Acknowledgement Statement. The physician or other practitioner must complete the acknowledgment at the time he or she is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. Physicians, other Practitioners, and Advanced Practice Professionals will also sign a Confidentiality and Security Agreement at the time of application for initial appointment and periodically as such Agreement may be revised, and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy and confidentiality policies of the Hospital. Completed Agreements will be maintained in the individual’s credentials file.

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

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72 42 C.F.R. §412.46(c)
73 HCA Ethics & Compliance Policy IS.SEC.005
74 42 C.F.R. §482.22(a)(2)
3.7.2.24. As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to immediately provide to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual’s professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the Federal Department/Section of Health and Human Services or any state, the receipt of a QIO citation, any change in legal status to reside and/or work in the USA, any investigation by an ABMS or AOA specialty board, any payer contract termination, any change in health status, any change in location of office or residence, any criminal investigation, and/or a quality denial letter concerning alleged quality problems in patient care.

3.7.3. APPLICATION PROCESSING

After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:75

3.7.3.1. **Department/Section Report:** The Medical Staff Services shall make available the application and all supporting materials to the Chairperson of each Department/Section in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department/Section to be assigned, appropriate to the applicant’s practice, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested.76 In the event that the applicant is the Department/Section Chairperson, the Medical Staff President or the Department/Section Vice-Chairperson shall make the evaluation and recommendations. The time frame for completion of the Department/Section report(s) shall be within 30 days of receipt of a complete application, but this time period may be reasonably delayed if it is determined that additional information is required to evaluate the applicant.77

3.7.3.2. **Credentials Committee Report:** The Credentials Committee shall review the application, supporting materials, and any such other available information as may be relevant to the applicant’s qualifications. The Credentials Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Section to be assigned, the clinical privileges to be granted, and any special conditions to be

75 MS.01.01.01, MS.06.01.07, MS.08.01.03
76 MS.01.01.01, MS.06.01.07, MS.08.01.03, LD.04.01.05
77 MS.01.01.01, MS.06.01.07, MS.08.01.03, LD.04.01.05
placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee within 30 days, but this time period may be reasonably delayed if it is determined that additional information is required to evaluate the applicant.

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

3.7.3.3.1. Inability to verify any of the information or credentials represented in the application;

3.7.3.3.2. Any unexplained gaps in medical staff membership, clinical privileges and/or work history;

3.7.3.3.3. Any other inconsistent or less than favorable information about the applicant’s professional qualifications, competence or character, as judged by the Department/Section Chairperson Credentials Committee, Medical Executive Committee or Board of Trustees.

3.7.3.4. **Medical Executive Committee Recommendation**: The Medical Executive Committee shall receive and review the application, supporting materials, the reports of the Credentials Committee, and any such other available information as may be relevant to the applicant’s qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Section to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee report; however this time period may be reasonably delayed if it is

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78 42 C.F.R. §482.22(a)(2), MS.02.01.01
determined that additional information is required to evaluate the applicant.

3.7.3.5. Effect of Medical Executive Committee Recommendation

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

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

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

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

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

3.7.3.6.2. If the Board does not adopt the recommendation of the Medical Executive Committee, the Board may either

79 42 C.F.R. §482.12(a)(2), 42 C.F.R. §482.22(a)(2), MS.01.01.01, MS.06.01.03, MS.06.01.07
refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may take unilateral action. If the matter is referred back to the Medical Executive Committee, the Medical Executive Committee shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.

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

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

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

3.8. CREDENTIALS SUBJECT TO ONGOING VERIFICATION

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

3.8.1. Current licensure;\(^{80}\)

\(^{80}\) MS.06.01.03, MS.06.01.07, MS.08.01.03
3.8.2. Drug Enforcement Administration registration

3.8.3. Professional liability insurance;

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

3.8.5. Privilege-specific requirements for current certifications as applicable to the clinical privileges granted; and,

3.8.6. Eligible to participate in the Federal Health Care Program. (The OIG Sanction Report, the GSA List shall be checked according to the frequencies defined by hospital policy.)\(^{81}\)

3.9. **ELIGIBILITY FOR REAPPOINTMENT**

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

3.9.1. Completed all medical records;

3.9.2. Completed all continuing medical education requirements;

3.9.3. Satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

3.9.4. Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested; and,

3.9.5. For individuals requesting clinical privileges, the individual had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the application shall be considered complete and processed further.

3.9.6 **Clinical Privileges After Age 70**

i) Individuals who desire to exercise clinical privileges after the age of 70 must apply for reappointment on a yearly basis.

ii) The applicant’s Clinical Service Executive Committee shall first assess the applicant’s professional qualifications, based on reappointment factors for continuation of clinical privileges.

iii) After review of the applicant’s request for continuation of clinical privileges by the clinical service, the Credentials Committee will determine whether or not the individual shall be required to undergo a physical. This assessment must be performed by a physician who is acceptable to the physician and the Credentials Committee.

iv) The examining physician shall provide a written report, addressing

\(^{81}\) HCA Ethics & Compliance Policy QM.002

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whether the individual has any physical condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively and effectively in a hospital setting. The report shall be provided directly to the committee. The examining physician shall be available to discuss any questions or concerns that the Committee may have.

3.10. EXPIRATION OF CURRENT APPOINTMENT

3.10.1. If an application is not submitted timely, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Only after a complete application is received shall an individual be considered for reappointment or renewal of clinical privileges.

3.10.2. If an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. The Board may subsequently grant reappointment and renewal of clinical privileges.

3.11. ASSISTANCE WITH EVALUATION

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

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

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

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

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

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

3.12. PROFESSIONAL PRACTICE EVALUATION

The Board has ultimate responsibility for the quality and appropriateness of patient care services.\(^{82}\) To meet this responsibility, the Board shall direct and enforce the

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\(^{82}\) LD.01.03.01
establishment of a performance improvement and quality assessment program with the requisite quality assessment processes. Processes shall include ongoing professional practice evaluation through the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other individuals with clinical privileges. The Medical Staff shall participate in quality assessment and performance improvement activities as defined in the Hospital’s Performance Improvement Plan.

The Medical Staff measurement, analysis and improvement activities used in ongoing professional practice evaluation shall be directed to assuring uniformly high quality and clinically appropriate care resultant from the performance of Staff members and others with clinical privileges. Such activities shall also be used to assure the fair and equitable treatment of each Staff Member and others with clinical privileges in appointment, reappointment, peer review and privileging processes. The data measurements and profiling established by the Medical Staff shall include clinical and other indicators directly attributable to quality and patient outcomes. Measures and their resultant analysis and performance improvement shall be managed within the established peer and quality review committees and Department/Sections of the Medical Staff for maximization of information and individual protections by state and federal peer review protections and immunity including the Health Care Quality Improvement Act.

Relevant information from Hospital performance improvement activities that is specific to an individual shall be considered and compared to aggregate information when these measures are appropriate for comparative purposes in evaluating the individual’s professional performance, judgment, clinical or technical skills. Any results of peer review regarding the individual’s clinical performance shall also be included. The Hospital may use epidemiological and statistical methods to compare practice patterns of individuals on dimensions of cost, service use, or quality (including process and outcome) of care. The Hospital may consider resource consumption and quality of care by an individual through an examination of patterns of health care delivery. Profiles may be constructed for individuals or groups of individuals based on Hospital, geographic, specialty, and type of practice or other characteristics. Performance profiles, including the results of performance based measures such as patterns of treatment, health care outcomes, and patient satisfaction shall be taken into account in evaluating applications for appointment or reappointment. The data, measures and profiles may include, but are not limited to, clinical and other information regarding each individual’s:

3.12.1. Quality and appropriateness of patient care, including patient care outcomes;
3.12.2. Review of operative and other clinical procedures performed and their outcomes;
3.12.3. Patterns of blood and pharmaceutical usage,
3.12.4. Requests for tests and procedures;
3.12.5. Length of stay patterns;
3.12.6. Morbidity and mortality data;
3.12.7. Practitioner’s use of consultants;
3.12.8. Performance as related to Healthcare Quality Alliance (HQA) core measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, data about Hospital Acquired Conditions (HAC), and other publicly-reported evidence-based performance measures;
3.12.9. Malpractice and professional liability experience;
3.12.10. Utilization of Hospital resources and facilities;
3.12.11. Timely, legible and accurate completion of patient medical records;
3.12.12. Professional conduct;
3.12.13. Attendance and participation in Medical Staff committee and Department/Section meetings, as required;
3.12.15. Maintenance of required levels of professional liability insurance coverage;
3.12.16. Attainment of continuing education requirements; and,
3.12.17. Attribution to sentinel events, medical errors or other risk occurrences.

The Board of Trustees shall be responsible for assuring the use of clinical and other measurements for the improvement of patient care. The sources for the information shall be identified by the Hospital and data quality shall be verified. Recommendations from the Medical Staff regarding their conclusions from Medical Staff and Hospital performance improvement and quality assessment shall be reported to the Board for their decision making and enforcement of actions for the improvement of patient care and execution of the quality assessment process.

Medical staff members and other individuals with clinical privileges are required to participate in all aspects of Medical Staff activities designed to verify the individual’s ongoing qualifications and competency. If at any time a Medical Staff member or other individual with clinical privileges fails to provide required information pursuant to a formal request by the Credentials Committee, Medical Executive Committee, the Chief Medical Officer, or the Chief Executive Officer, the individual’s clinical privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party, without the individual having a right to a hearing or appeal. For purposes of this section, ‘required information’ shall refer to (1) physical or mental examination reports as specified elsewhere in these Bylaws, or (2) information from another healthcare facility or agency. If voluntary relinquishment of clinical

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87 Introduction to MS.08.01.03
88 Introduction to MS.08.01.03
89 Introduction to MS.08.01.03
90 Introduction to MS.08.01.03
91 Hospital’s Improvement Initiatives
privileges occurs while the individual is subject to an investigation, this will be reported in accordance with the requirements of the National Practitioner Data Bank.  

If voluntary relinquishment of clinical privileges occurs while the individual is subject to formal investigation (professional review activity) as described in paragraph 6.1 of these Bylaws, this will be reported in accordance with the requirements of the National Practitioner Data Bank.

3.13. PROVISIONAL STATUS AND PROCTORING

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

3.13.1. For initial appointment/initial clinical privileges: At the time of initial appointments and initial granting of clinical privileges, the medical staff shall determine a plan for conducting focused professional practice evaluation, during which the practitioner shall be on provisional status. The evaluation plan shall include method(s) and the time period of evaluation and may be subject to an extension of time for a total period not to exceed two years (24 months). A period of focused professional practice evaluation shall be implemented for all initially requested privileges. Each individual subject to provisional status may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department/Section to which the individual is affiliated. The provisional status individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department/Section as appropriate to the patient care and services provided by

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92 Medical Staff Leader Monthly, October 2008, Horty Springer & Mattern
94 MS.08.01.01
95 AMA Board of Trustees Report 30-A-94
96 MS.08.01.01
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Department/Section members. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual’s eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual’s performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status, or be extended on provisional status for an additional period not to exceed a total of twenty-four (24) months. Advancement shall be based upon a favorable recommendation of the individual’s Department/Section Chairperson based on the Chairperson’s review of the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and a favorable recommendation of the Credentials Committee, Medical Executive Committee, and approved by the Board. No one may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the Medical Executive Committee and the Board, an individual’s failure to complete the required number of cases needed to complete focused professional practice evaluation shall be deemed a voluntary relinquishment of membership and clinical privileges; such individual shall not be entitled to the hearing and appeal rights under these Bylaws. Failure to advance to a non-provisional status due to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws.

3.13.2. For individuals with existing privileges who are requesting new privileges: A period of focused professional practice evaluation shall be implemented for all initially requested privileges. Medical Staff members or other individuals with existing clinical privileges who are requesting new privileges may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department/Section to which the individual is affiliated. In the event new privileges are requested for which there are no other Medical Staff members or other individuals with existing clinical privileges and competence to proctor and evaluate someone in the new area of practice, the Credentials Committee, the Medical Executive Committee, and the Board shall have the option of specifying requirements for other evidence of competence, including but not limited to reports of completion of an accredited training program, evaluations from competent instructors, external peer review, and/or evidence of proctoring at another hospital. The individual requesting new privileges shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department/Section as appropriate to the new clinical privileges being requested. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual’s actual clinical competence for the new clinical privileges granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual’s performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The individual’s Department/Section Chairperson shall review the proctoring reports,
chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Credentials Committee, the Medical Executive Committee, and the Board.

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

3.13.4. Duties of Individuals on Provisional Status

3.13.4.1. During the provisional period, an individual must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed or observed by the Department/Section Chairperson or other designated observers.

3.13.4.2. If a new member of the Medical Staff or other individual with clinical privileges fails, during the provisional period, to:

3.13.4.2.1. Participate in the required number of cases;

3.13.4.2.2. Cooperate with the monitoring and observation conditions; or

3.13.4.2.3. Fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities, the individual's Medical Staff appointment and the clinical privileges shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for initial appointment or privileges for two years.

3.13.4.3. If a member of the Medical Staff who has been granted additional clinical privileges or other individual granted additional clinical

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privileges fails, during the focused evaluation period, to participate in the required number of cases or cooperate with the monitoring and observation conditions, the additional clinical privileges shall be automatically relinquished at the end of the focused evaluation period, unless an extension is granted by the section/department and MEC and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for six (6) months.

3.13.4.4. If a member of the Medical Staff or other individual with clinical privileges who has been in a provisional period for an evaluation of competence fails to participate in the required number of cases or cooperate with the monitoring and observation conditions, the clinical privileges under review shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for two years.

3.13.4.5. When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual shall be entitled to a hearing and appeal.

3.14. CONDITIONAL APPOINTMENT, REAPPOINTMENT OR PRIVILEGES

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

3.14.1.1. If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, and successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.

3.14.1.2. If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, but does not adhere to the conditions or completes the requirements specified in the conditional appointment, reappointment, or privileges then the corrective action process as set forth in Article Six of these Bylaws shall commence.

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

3.14.3. In the event an applicant for reappointment or renewal of privileges is the subject of a formal investigation (professional review activity) or hearing/appeal at the time reappointment or renewal of privileges is being considered, a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the investigation or hearing. Alternatively, depending on the circumstances, the application for reappointment or renewal of privileges, in the sole discretion of the Medical Executive Committee, may be deemed incomplete until such time the investigation and/or hearing/appeal process has concluded. Such determination by the Medical Executive Committee that the application is incomplete shall not constitute an adverse action entitling the applicant to the hearing and appeal procedures set out in Article Seven of these Bylaws.

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

3.15. PREVIOUSLY DENIED OR TERMINATED APPLICANTS

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

3.16. CHIEF MEDICAL OFFICER (MEDICO-ADMINISTRATIVE OFFICER)

3.16.1. DEFINED

A medico-administrative officer is a Practitioner who is employed by or contracts with the Hospital as a Chief Medical Officer (CMO), or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities, and may also include clinical responsibilities.
3.16.2. STAFF APPOINTMENT, CLINICAL PRIVILEGES AND OBLIGATIONS

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

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

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

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

3.17. INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.17.1. QUALIFICATIONS AND SELECTION

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

3.17.2. EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

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

3.18. LEAVE OF ABSENCE

A Medical Staff Member or Advanced Practice Professional (APP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Chief Executive Officer/CMO/Medical Staff President. The request must state the beginning date and ending date for the period of leave desired, which may not exceed two years, and includes the reasons for the request. The Credentials Committee shall review leave of absence requests and recommend to the Medical Executive Committee. The Medical Executive Committee shall recommend to the Board of Trustees, but in extenuating circumstances such as military leave, the Chief Executive Officer/CMO and Medical Staff President shall have the authority to approve a leave of absence and their actions shall be reported to the Credentials Committee, the Medical Executive Committee and Board of Trustees. During the period of leave, the Practitioner or APP shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the Medical Staff Member or APP requesting the leave. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records. Exceptions shall be allowed only in the event that a Medical Staff Member or APP has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

3.18.1. MEDICAL LEAVE OF ABSENCE

Members of the Medical Staff and APPs must report to the Chief Executive Officer/CMO/Medical Staff President any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. A Medical Staff Member or APP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or health issue (as defined in Section 3.20 below). If an individual is unable to request a medical leave of absence because of a physical or psychological condition or health issue, the Medical Staff President/CMO or Chairperson of the individual’s
Department/Section may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of this action.

3.18.2. MILITARY LEAVE OF ABSENCE

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

3.18.3. EDUCATIONAL LEAVE OF ABSENCE

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

3.18.4. PERSONAL/FAMILY LEAVE OF ABSENCE

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

3.18.5. REINSTATEMENT FOLLOWING A LEAVE OF ABSENCE

3.18.5.1. The Medical Staff Member or APP on leave of absence must request reinstatement of Medical Staff membership and/or clinical privileges by submitting a written notice to the Medical Staff President. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Three, or if changes have occurred, a detailed description of the nature of the changes. The Staff Member or APP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual’s physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. If the medical leave of absence was for purposes of treatment for a health issue, then the conditions of reinstatement shall require compliance with the section of these Bylaws addressing practitioner
health issues. If the leave of absence has extended past the Practitioner’s or APP’s reappointment time, he/she will be required to submit an application for reappointment in accordance with Article Three of these Bylaws and the reinstatement shall be processed as a reappointment. The Medical Staff President/CMO will forward the request for reinstatement to the individual’s Department/Section Chairperson for a recommendation. The Department/Section Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Article Five, Section 5.2.4. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

3.18.5.2. Absence for longer than two years will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Medical Staff President and the Chief Executive Officer/CMO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

3.18.5.3. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, this will result in automatic relinquishment of Medical Staff appointment and clinical privileges and the determination will be final, with no recourse to a hearing and appeal.

3.18.6. FAILURE TO REQUEST REINSTATEMENT

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

3.19. RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to the Medical Staff Services. Resignation of Medical Staff membership and/or clinical privileges may be granted for a Practitioner or APP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner’s or APP’s Department/Section Chairperson, the Medical Executive Committee, and the Board shall review letters of resignation. Once submitted, a resignation may not be withdrawn until it has been considered by the Board. If a Practitioner or APP requests to withdraw a
resignation before the resignation is accepted by the Board, the request for withdrawal shall also be forwarded to the Board for consideration. The Board may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board, the Practitioner or APP will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of a professional review activity regarding concerns about behavior, conduct, competence, or professional performance, a report shall be submitted to the state professional licensing board for reporting to the National Practitioner Data Bank (NPDB), as required by federal law and state law.\textsuperscript{101}

3.20. PRACTITIONER HEALTH ISSUES

This section of the Bylaws applies to all individuals who provide patient care services in the Hospital and who have been granted clinical privileges. The Hospital and its Medical Staff are committed to providing quality care, which can be compromised if an individual with clinical privileges is suffering from a health issue. "Health issue" means any physical, mental, or emotional condition, or personality disorder including alcohol or substance abuse, cognitive deterioration or loss of motor skills due to the aging process, and use of prescription medications, which could adversely affect an individual's ability to practice safely and competently.\textsuperscript{102,103} It also includes a contagious disease which could compromise patient safety or jeopardize other health care workers. The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges, for the purpose of facilitating the timely recognition and reporting of health issues. It is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a Member of the Medical Staff or who has clinical privileges has a health issue. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA).

3.20.1. SELF-REPORTING

During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff Member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change.\textsuperscript{104}

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

3.20.2. THIRD PARTY REPORTS

If a Medical Staff Member, Advanced Practice Professional, or Hospital

\textsuperscript{101} Health Care Quality Improvement Act, 42 U.S.C. §11135, 45 C.F.R. 60.9(a)(ii)(A)
\textsuperscript{102} MS.11.01.01
\textsuperscript{103} AMA Definition of Impairment
\textsuperscript{104} MS.11.01.01

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employee witnesses symptoms of a health issue, they should report the incident. Patients, family members, or others who witness symptoms of a health issue shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting symptoms of a health issue shall be kept strictly confidential. Medical Staff members and others, as appropriate, shall be educated about recognition of health issues specific to physicians and others with clinical privileges, including education about warning signs. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

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

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

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

3.20.2.2.2. Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Credentials Committee.

3.20.3. CONCERNS REQUIRING AN IMMEDIATE RESPONSE

3.20.3.1. Anyone who is concerned that an individual has a health issue that poses an immediate threat to the health and safety of patients or to the orderly operation of the Hospital, shall immediately notify the relevant Department/Section Chairperson, the Medical Staff President, the Chief Medical Officer, or their designees.

3.20.3.2. The Department/Section Chairperson, Medical Staff President, and/or the Chief Medical Officer (or their designees) shall immediately assess the individual and, if necessary to protect patients, may relieve the individual of patient care responsibilities. The affected individual’s hospitalized patients may be assigned to another individual with appropriate clinical privileges or to the appropriate practitioner on call. The wishes of the patient(s) shall be considered in the selection of a covering practitioner. The affected patients shall be informed that their practitioner is unable to proceed with their care due to illness.

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105 MS.11.01.01
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3.20.3.3. Following the immediate response, the Department/Section Chairperson, Medical Staff President, and/or the Chief Medical Officer (or their designees) shall file formal reports as described in these Bylaws, in order for the health issue to be more fully assessed and addressed by the Credentials Committee.

3.20.4. REVIEW BY CREDENTIALS COMMITTEE

3.20.4.1. The Credentials Committee shall act expeditiously in reviewing concerns regarding a potential health issue. As part of its review, the Credentials Committee may meet with the individual(s) who initially reported the concern.

3.20.4.2. If the Credentials Committee believes that the practitioner has or might have a health issue, it shall meet with the individual. At this meeting, the individual should be told that there is a concern that his or her ability to practice safely and competently may be compromised by a health issue and advised of the nature of the concern, but should not be told who initially reported the concern.

3.20.4.3. The Credentials Committee may require that the individual (i) undergo a physical or mental examination, (ii) submit to an alcohol or drug screening test (blood, hair, or urine), and/or (iii) be evaluated by a physician or organization and have the results of any such evaluation provided to it, in accordance with the Hospital policy regarding Medication Diversion. The Credentials Committee shall select the health care professional(s) or organization to perform the testing and/or evaluation.

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

3.20.5. OUTCOME OF INVESTIGATION

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

3.20.5.1. Whether the individual has a health issue, or what other problem, if any, is affecting the individual under investigation;

3.20.5.2. If the individual has a health issue, the nature of the health issue and whether it is classified as a disability;

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

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

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

3.20.5.6. If the Credentials Committee determines that there is a reasonable accommodation that ensures patient safety, the Credentials Committee shall attempt to work out a voluntary agreement with the individual. The Chief Executive Officer/CMO shall be kept informed of the voluntary agreement before it becomes final and effective. Based on the severity and nature of the health issue, the Credentials Committee may recommend to the practitioner that he or she:

3.20.5.6.1. take a voluntary medical leave of absence to receive appropriate medical treatment or participate in a rehabilitation program; or

3.20.5.6.2. voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the practitioner is able to practice safely and competently; or

3.20.5.6.3. voluntarily agree to specific conditions.

3.20.5.7. If the Credentials Committee recommends that the individual receive medical treatment or participate in a rehabilitation program, it may assist the individual in identifying appropriate resources.

3.20.5.8. If the individual does not agree to abide by the Credentials Committee’s recommendations, the matter shall be referred to the Medical Executive Committee for a review and possible investigation to be conducted pursuant to the Medical Staff Bylaws or any applicable credentials policy.

3.20.5.9. If the individual agrees to abide by the recommendations of the Credentials Committee, a confidential report will be made to the applicable Department/Section Chairperson, the Medical Staff President, and the Chief Medical Officer. In the event any of these individuals is concerned that the action of the Credentials Committee is not sufficient to protect patients or other health care workers, the matter will be referred back to the Credentials Committee with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee for review and possible investigation.

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

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

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

3.20.6. TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES

If it is determined that the individual has a health issue that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

3.20.6.1. An individual with a health issue shall not be reinstated until it is established, to the Credential Committee and MEC’s satisfaction, that the individual has successfully completed a rehabilitation program in which the Credentials Committee and MEC has confidence, or has received treatment for a medical or psychological health issue such that the condition is under sufficient control and the individual is enrolled in a professional assistance program established by their appropriate licensing agency.

3.20.6.2. The Medical Staff is not required to extend membership or privileges to an individual with a health issue, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.

3.20.6.3. Upon sufficient proof that the individual who has been found to have a health issue has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the individual for reinstatement of Medical Staff membership or clinical privileges.
3.20.6.4. In considering an individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

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

3.20.6.5.1. Whether the individual is participating in the program or treatment;

3.20.6.5.2. Whether the individual is in compliance with all of the terms of the appropriate licensing agency’s program or treatment plan;

3.20.6.5.3. Whether the individual attends AA/NA meetings regularly (if appropriate);

3.20.6.5.4. To what extent the individual’s behavior and conduct are monitored;

3.20.6.5.5. Whether, in the opinion of the treating physician, the individual is rehabilitated or the health issue is under control;

3.20.6.5.6. Whether any conditions are required to allow the individual to safely resume practicing (e.g., supervision, limitation on work hours, limitation on privileges);

3.20.6.5.7. Whether an after-care program has been recommended to the individual (if appropriate), and if so, a description of the after-care program; and,

3.20.6.5.8. Whether, in the opinion of the treating physician, the individual is capable of resuming practice and providing continuous, competent care to patients.

3.20.6.6. The Medical Staff has the right to require opinion(s) from other physician consultants of its choice. Before making a recommendation on a request for reinstatement or lifting conditions, the Credentials Committee may request the practitioner to undergo an examination by a physician of its choice to obtain a second opinion on the practitioner’s ability to practice safely and competently. The Credentials Committee shall make a recommendation to the Medical Executive Committee.

3.20.6.7. Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:

3.20.6.7.1. The individual must identify a physician or peer who is willing to assume responsibility for the care of his/her
patients in the event of his/her inability or unavailability;

3.20.6.7.2. If the practitioner was granted a formal medical leave of absence, the final decision to reinstate a individual's clinical privileges must be approved pursuant to the Leave of Absence process set forth in the Medical Staff Bylaws;

3.20.6.7.3. The individual may be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.

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

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

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

3.20.6.11. If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements. 107

3.20.6.12. If at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the individual or others, the Chief Medical Officer or Chief Executive Officer may contact law enforcement authorities.

107 MS.11.01.01

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3.20.6.13. Nothing in this Section precludes immediate referral to the Medical Executive Committee or the elimination of any particular steps in this Section in dealing with conduct that may compromise patient care.

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

3.21. REQUIREMENTS REGARDING PROFESSIONAL CONDUCT

3.21.1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus it is the policy of the Hospital to require all individuals working in the Hospital, including Medical Staff members, APPs, and other individuals with clinical privileges to treat others with respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. In dealing with incidents of unprofessional or inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Hospital are paramount concerns.

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

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

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

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

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

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

3.21.3.6. Disruption of Hospital or Medical Staff operations, Hospital or Medical Staff committee(s) or Department/Sectional affairs.
3.21.3.7. Imposing onerous requirements on the nursing staff, other Hospital staff, Hospital-affiliated providers, APPs, or contractors, such as assigning work that is outside of their scope of practice as allowed under their state license, or outside of the scope of their Hospital job description, Hospital-approved duties, or clinical privileges, or contrary to Hospital policies and procedures, or that would otherwise jeopardize patient safety, quality of patient care or the Hospital’s or staff member’s compliance with laws, regulations or standards.

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

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

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

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

3.21.3.12. Sexual harassment including conduct or behavior that includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, particularly if:

3.21.3.12.1. Submission to such conduct is made either explicitly or implicitly a term or condition of employment.

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

3.21.3.12.3. Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.

3.21.3.12.4. Sexual harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations.
3.21.4. Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospital policy, local and State laws.

3.21.5. The Medical Staff leadership and Hospital leaders may provide education to all Medical Staff members and other individuals with clinical privileges regarding appropriate professional behavior and conduct. The Medical Staff leaders and Hospital leaders shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of policies associated with appropriate professional conduct and shall institute procedures to facilitate prompt reporting of inappropriate or unprofessional conduct, and prompt action as appropriate under the circumstances.

3.21.6. A practitioner who is employed by or has contracted with the hospital who engages in unprofessional or inappropriate conduct shall be dealt with in accordance with the Hospital’s Human Resources policies. A Member of the Medical Staff and other individual with clinical privileges who engages in unprofessional or inappropriate conduct shall be dealt with in accordance with this Section of the Bylaws. Unprofessional or inappropriate conduct resulting from a health issue as defined in the Practitioner Health Issues section of these Bylaws should be dealt with using whichever Section is most appropriate for the conduct in question. If the matter involves an employed Practitioner or APP, the Chief Executive Officer/CMO shall consult with appropriate Medical Staff leaders, and legal counsel will determine which of any applicable policies will be applied.

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

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

3.21.9. Nurses, other Hospital employees, or other individuals who observe, or are subjected to, unprofessional or inappropriate conduct by a Practitioner shall notify their supervisor about the incident or, if their supervisor’s behavior is at issue, they shall notify the Chief Executive Officer/CMO (or designee). Any Practitioner who observes such behavior shall notify the Chief Executive Officer/CMO directly. Upon learning of the occurrence of an incident of unprofessional or inappropriate conduct, the supervisor/Chief Executive Officer/CMO shall request that the individual who reported the incident
document it in writing. If the observer of inappropriate or unprofessional conduct does not wish to provide a written report, the supervisor/Chief Executive Officer/CMO may document it, while also attempting to ascertain the observer’s reasons for declining and providing encouragement to do so.

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

3.21.10.1. The date and time of the questionable behavior;
3.21.10.2. A factual description of the questionable behavior;
3.21.10.3. The name of any patient or patient’s family members who were involved in the incident, including any patient or family Member who witnessed the incident;
3.21.10.4. The circumstances which precipitated the incident;
3.21.10.5. The names of other witnesses to the incident;
3.21.10.6. Consequences, if any, of the unprofessional or inappropriate conduct as it relates to patient care, personnel, or Hospital operations;
3.21.10.7. Any action taken to intervene in, or remedy, the incident; and,
3.21.10.8. The name and signature of the individual reporting the matter.

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

3.21.12. If a reporting individual is unwilling or uncomfortable with reporting unprofessional or inappropriate conduct using the procedure described in Section 3.21.8, then a report of the incident may be made to the Hospital’s Ethics & Compliance Officer or the Ethics Line at 1-800-455-1996.

3.21.13. The supervisor/Chief Executive Officer/CMO who took the report shall follow-up with the individual who made the report by informing the individual that the matter is being reviewed, thanking the individual for reporting the matter, and instructing the individual to report any further incidents of inappropriate or unprofessional conduct. The individual making the report shall also be informed that, due to legal confidentiality requirements, no further information can be provided regarding the review of the matter.

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

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

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

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

3.21.18. Following this meeting, a letter shall be sent to the Practitioner. The letter shall describe the unprofessional or inappropriate conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter should also confirm that the Practitioner could be placed on Precautionary Suspension for a period of time, a request that a formal investigation could be commenced pursuant to the Bylaws, and any other remedies could be taken to adequately protect the patients, hospital staff and others from continued unprofessional or inappropriate conduct. The letter will also define the conditions of continued practice at the Hospital which shall make continued Medical Staff membership and clinical privileges contingent on the Practitioner’s adherence to the conditions and expectations for professional conduct. The Practitioner shall be required to sign it. The Medical Staff President/CMO shall cause records of the second meeting and the letter to the Practitioner to be filed in the confidential portion of the credentials file. The Chief Executive Officer/CMO shall cause records of the second meeting and the letter to the Practitioner to be filed in peer review files. If the Practitioner refuses to sign the letter, the Chief Executive Officer/CMO and/or the Medical Staff President shall request that a formal investigation be commenced pursuant to the Bylaws and the advice of legal counsel should be obtained.

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

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

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

4. **CATEGORIES OF THE MEDICAL STAFF**

4.1. **CATEGORIES**

The Staff shall include the categories of Active Staff, Affiliate Staff, and Provisional Staff. At the time of appointment and at the time of each reappointment, the Medical Staff Member’s staff category shall be recommended by the Medical Executive Committee and approved by the Board. Moonlighting Residents and Advance Practice Professionals (APP’s) must be credentialed and are recognized by the medical staff, but shall not be considered members of the Medical Staff.

4.2. **LIMITATIONS ON PREROGATIVES**

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

4.3. **ACTIVE STAFF**

4.3.1. **REQUIREMENTS FOR ACTIVE STAFF**

The Active Staff category shall consist of Practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight. To qualify for the Active Staff category, the Medical Staff Member shall contribute to the following types of activities during the last term of appointment, as determined by the Department/Section Chairperson and approved by the Board of Trustees, including during provisional status during an initial term of appointment:

- Term of office as a Medical Staff Officer or Department/Section Chairperson;

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109 Health Care Quality Improvement Act, 42 U.S.C. §11112(c)(1 – 2)

110 42 C.F.R. §482.22(c)(3)

111 MS.06.01.03, Introduction
• Membership on the Board of Trustees;
• Medical Staff committee Chairperson;
• Medical Staff committee Member;
• Timely response to on-call duties when on-call;
• Serving as a proctor to a practitioner under focused professional practice evaluation;
• Serving as a physician advisor or peer reviewer;
• Timely completion of medical records (e.g., Member had patient admissions and had no delinquencies in completion of their records during term of appointment);
• Serving on a Hospital committee or team/task group;
• Supervisory duties, e.g., serving as the medical director of a Hospital Department/Section, or supervision of a Limited Licensure Practitioner;
• Providing education to fellow Medical Staff members, e.g., grand rounds, formal educational presentation, author of a medical staff newsletter article; or,
• Supervising participants in a Hospital-sponsored professional graduate education program.
• Demonstrate by way of other substantial involvement in the activities of the Medical Staff or Medical Center a genuine concern and interest in the Medical Center.
• At the time of reappointment to the Medical Staff, the member must have at least ten (10) or more patient encounters (admissions, consultations) at the Medical Center, or its affiliated facilities, within the previous two year time period in order to be considered eligible for continuation of Active Staff membership. If the Active Staff member has not had ten (10) or more patient encounters within that two year time period, the Active Staff member will automatically be moved to the Affiliate Staff category. Radiology, Anesthesia, Emergency, Neonatology and Pathology are exempt and may remain Active if in contracted group. Exemption from this requirement also extends to physicians who participate in on-call schedules at Wesley Medical Center; physicians who are in specialties who provide consultation to the hospital on a case by-case basis may be exempted by their Service/Department; and Medical Directors for outpatient services.

4.3.2. PREROGATIVES OF ACTIVE STAFF

Members of the Active Staff shall be eligible to vote and hold office within the Medical Staff organization. Any Active Staff Member may attend Medical Staff and Department/Section meetings and serve on committees of the Board, Medical Staff or Hospital. Members in the Active Staff category shall compose the group defined as the Organized Medical Staff.
4.3.3. OBLIGATIONS OF ACTIVE STAFF

Each Member of the Active Staff shall discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her Medical Staff Department/Section or Division as specified by the requirements of the assigned Medical Staff Department/Section\textsuperscript{112}; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; attend Medical Staff and Department/Section meetings, as required; pay staff dues as determined by the Medical Staff and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations including any future changes to these Bylaws or Rules and Regulations, and comply with directives issued by the Medical Executive Committee.

4.4. AFFILIATE STAFF

4.4.1. REQUIREMENTS FOR AFFILIATE STAFF

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

4.4.2. PREROGATIVES OF AFFILIATE STAFF

Members of the Affiliate Staff may visit their hospitalized patients, and review their patients’ medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures. Affiliate Staff shall not be eligible to vote or hold office within the Medical Staff organization.

An Affiliate Staff member may order outpatient diagnostic tests and therapeutic services, and must refer all patients for admission to Active Medical Staff members. An Affiliate Staff member may order outpatient laboratory, radiology, diagnostic cardiopulmonary or electrodiagnostic testing e.g., PFT, ECG, EEG)

In order for an Affiliate Staff member to resume admitting and other clinical

\textsuperscript{112} 42 C.F.R. §482.55(b)(2)
privileges, they will, at a minimum, be required to have:

a) Proctored co-admissions or consultations as outlined by the practitioner’s clinical department/service executive committee.

b) A Focused Professional Practice Evaluation (FPPE) in the clinical area of application.

Physician must complete orientation that provides information about the following:

- Core Measure
- Blood Usage
- Code of Conduct
- MRSA
- Safety
- Patient Status
- Right to Appeal Discharge
- Computer Orientation

4.4.3. OBLIGATIONS OF AFFILIATE STAFF

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

An Affiliate Staff member

a) Must abide by the Medical Staff Bylaws, the Medical Center Bylaws and all other applicable standards, policies and rules of the Staff and Medical Center.

b) Shall not be required to attend meetings, but are encouraged to attend meetings of the General Medical Staff.

c) Pay staff dues as determined by the Medical Staff.

d) May serve on Medical Staff committees.

e) Shall be assigned to a clinical service.

An Affiliate Staff member must reapply for staff membership as outlined in the Medical Staff Bylaws.

4.5. HONORARY RECOGNITION

4.5.1. REQUIREMENTS FOR HONORARY RECOGNITION
Membership on the Honorary Staff is by invitation and is restricted to two classes of practitioners: 1) Staff members whom, upon retirement from practice, the Executive Committee of the Medical Staff recommends to the Board of Trustees for this status in recognition of long-standing service to the Medical Center or other noteworthy contributions to its activities; and 2) other practitioners with outstanding professional attainments as determined by the Executive committee of the Medical Staff.

4.5.2. **PREROGATIVES OF HONORARY RECOGNITION**

Honorary Staff members may attend meetings of the Staff, but they have no vote and none of the specific qualifications, prerogatives or obligations provided for other Staff categories.

4.6. **CHANGE IN STAFF CATEGORY**

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

4.7. **MEDICAL STUDENTS AND, RESIDENTS**

The terms, “medical students,” and “residents,” (hereinafter referred to collectively as “house staff”) as used in these Bylaws, refer to Practitioners who are currently enrolled in a graduate medical education program sponsored by the University of Kansas School of Medicine – Wichita (UKSM-W) and who, as part of their educational program, receiving training and provide health care services at the Hospital. House staff shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. House staff shall be credentialed by Wichita Center for Graduate Medical Education (WCGME) in accordance with provisions in a written affiliation agreement between the Hospital, WCGME, and UKSM-W Application for residency must be submitted by the applicant to the University of Kansas School of Medicine – Wichita residency program. The completed residency application shall be submitted by the UKSM-W Residency Program to the Wichita Center for Graduate Medical Education (WCGME). WCGME will be responsible for obtaining all credentialing information per the Participation Agreement between WCGME and Wesley Medical Center.

A copy of these documents, along with a copy of the residency application, shall be forwarded to the Wesley Medical Education Office. The Medical Education Office will be responsible for maintaining these resident files, verification of Kansas licensure for all residents on an annual basis, and checking the OIG Sanction Report and GSA List to ensure that no resident applicant is listed.

The Medical Education Office shall submit a report to the Medical Staff Executive Committee which shall include all new residents accepted into UKSM-W Residency Program, resident advancements, residents who have completed their residency training, and/or any other change of status involving residents. The action and effect of action of
the Medical Staff Executive Committee and Board of Trustees are as outlined in these bylaws.

The Graduate Medical Education department will send a report to the Medical Executive Committee. This report will include competencies that are available in each resident specialty/year and what competencies the residents have to be approved for by the program director and the Graduate Medical Education Committee.

In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a house staff Practitioner to provide services at this Hospital. House staff Practitioners may render patient care services at the Hospital only pursuant to and limited by the following:

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

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

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

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

4.7.5. The KU/WCGME Graduate Medical Education Committee (GMEC) and/or the KU Designated Institutional Officer (DIO) shall be responsible for overseeing
house staff Practitioners and shall communicate to the Medical Executive Committee and the Board about the patient care provided by, and the related educational and supervisory needs of, the participants in the professional graduate education programs, including demonstrated compliance with any residency review committee citations as applicable to the program.\textsuperscript{114}

4.7.6. As defined in Section 4.7 above, house staff Practitioners are distinguished from Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g., “moonlighting” or locum tenens coverage) and not as part of their educational program. Such Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in these Bylaws and shall be subject to the credentialing procedures specified in these Bylaws in the same manner as a Practitioner seeking appointment to the Medical Staff.

4.7.7 MOONLIGHTING RESIDENTS

4.7.7.1. QUALIFICATIONS
A moonlighting resident must:

4.7.7.1.1. Maintain a current Kansas license, malpractice insurance and DEA registration.

4.7.7.1.2. Be a current resident in an approved ACGME program.

4.7.7.2 PREROGATIVES
A moonlighting resident:

4.7.7.2.1. May evaluate and treat patients in the clinical areas in which he/she has applied for privileges.

4.7.7.2.2. Does not have admitting privileges.

4.7.7.3. DUTIES

4.7.7.3.1. Must abide by the Medical Staff Bylaws, the Medical Center Bylaws, and all other applicable standards, policies and rules of the staff and Medical Center.

4.7.7.3.2. Practice under observation of the Chairperson of the clinical service in which his/her patients are classified.

4.7.7.3.3. Is subject to observation by the Officers and the members of the Staff regarding his/her moral and professional qualifications of conduct.

4.7.7.3.4. Shall be assigned to a clinical service.

4.7.7.3.5. May attend meetings of the Medical Staff in which he/she is a member.

4.7.7.3.6. Is not eligible to hold office in the Staff organization, to vote at clinical service or medical staff meetings, to serve as staff or service officers, or to chair any standing committee.

4.7.7.3.7. Shall not pay staff dues.

\textsuperscript{114} MS.04.01.01

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4.8. ADVANCED PRACTICE PROFESSIONALS/ALLIED HEALTH PROFESSIONALS

The term, “Advanced Practice Professional” (APP) also known as Allied Health Professionals (AHP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for practice parameters shall be approved by the Board and shall be credentialed through the same processes as a Medical Staff Member, as described in Article Three, and shall be granted practice parameters as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although APPs are credentialed as provided in these Bylaws, in Article Three, they are not eligible for Medical Staff membership. They may provide patient care services only to the extent of the practice parameters that have been granted. The Board has determined the categories of individuals eligible for practice parameters as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (APRN). 115

Other categories of dependent healthcare professionals who are not hospital employees but who provide patient care services in support of, or under the direction of a Medical Staff Member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Categories of dependent healthcare professionals subject to such Hospital processes, policies and procedures shall include, without limitation, Health Care Industry Representatives (HCIRs), operating room nurses and technicians, perfusionists, surgical first assistants, clinical assistants, autotransfusionists, orthotists/prosthetists, registered and practical nurses, dental technicians, lactation consultants, doulas, and medical assistants. Hospital policies and procedures shall govern the actions and patient care services provided by dependent healthcare professionals. These categories of dependent healthcare professionals are not considered Advanced Practice Professionals. Although a Medical Staff Member may provide employment, sponsorship and supervision of a non-hospital-employed dependent healthcare professional through the terms of a sponsorship agreement, which shall impose binding responsibilities upon the Medical Staff Member, these Bylaws shall not apply to such dependent healthcare professionals. Dependent healthcare professionals are listed here only to distinguish them from APPs.

A Medical Staff Member who fails to fulfill the responsibilities as outlined in the Rules and Regulations and/or in a sponsorship agreement for the supervision of an APP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws.

4.8.1. REQUIREMENTS FOR ADVANCED PRACTICE PROFESSIONALS

As permitted by state law, APPs shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. The terms of the accountability of the APP to the Medical Staff Member and the terms for supervision of the APP by a Medical Staff Member shall be documented in a sponsorship agreement between

115 42 C.F.R. §482.12(a)(1)
the APP and the sponsoring Medical Staff Member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for practice parameters shall contain all of the following information:

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

4.8.1.2. Completed sponsoring Medical Staff Member's evaluation;

4.8.1.3. Requested practice parameters shall specify the degree of supervision required for the performance of each practice parameter, and shall be signed by the sponsoring Medical Staff Member(s);

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

4.8.2. PREROGATIVES OF ADVANCED PRACTICE PROFESSIONALS

APPs shall not be eligible to vote, or hold office within the Medical Staff organization. An APP may attend Medical Staff or Department/Section/Division meetings if invited. An APP may write the order for inpatient, outpatient, or observation admission for an attending/admitting physician. Patients may be admitted only upon order of a medical staff member so authorized. APPs may provide patient care services only when such have been ordered by the employing or consulting medical staff member and as defined by the rules and regulations of the Credentials Committee.

4.8.3. OBLIGATIONS OF ADVANCED PRACTICE PROFESSIONALS:

Each APP shall discharge the basic obligations of Staff members as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

5. CLINICAL PRIVILEGES/PRACTICE PARAMETERS

5.1. EXERCISE OF PRIVILEGES/PRACTICE PARAMETERS

Every Practitioner or Advanced Practice Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership, shall, in connection with such practice and except as provided in Sections 5.3 and 5.4 below, be entitled to exercise only those clinical privileges/practice parameters specifically granted to him/her by the Board. The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this State or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual’s current competence, and shall be subject to the Rules and Regulations of the Department/Section. Clinical privileges/practice parameters may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate

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116 MS.03.01.01, MS.03.01.03, MS.06.01.07
clinical privileges/practice parameters in any case when the clinical needs of the patient exceed the clinical privileges/practice parameters of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department/Section/Division Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

5.2. DELEGATION OF PRIVILEGES/PRACTICE PARAMETERS

5.2.1. APPLICATION

Clinical privileges/practice parameters may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Every application for appointment and reappointment must contain a request for the specific clinical privileges/practice parameters desired by the applicant. An applicant for clinical privileges/practice parameters shall be subject to the same obligations as are imposed upon an applicant for Staff appointment, as provided in Article Three, Section 3.5. Only those clinical privileges/practice parameters supported by evidence of competence and proof that the applicant meets the criteria for each privilege/parameter will be processed through the application process. Pursuant to Section 3.7.2, the responsibility for producing a complete application and request for clinical privileges/practice parameters shall be the applicant’s.

5.2.1.1. Special Conditions For Oral Surgeons, Dentists, and Podiatrists

Requests for clinical privileges from oral surgeons, dentists, and podiatrists are processed in the manner specified in this Article. Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Chairperson of the Surgery Service. Surgical procedures performed by podiatrists are under the overall supervision of the Chairperson of the Orthopedics. An oral surgeon, dentist, or podiatrist with the requisite qualifications may be granted the privilege of performing the admission history and physical examination and assessing the medical risks of the proposed procedure to the patient but only in those instances where the patient has no known current medical problems. In all other circumstances, an MD or DO member of the Medical Staff must perform a basic medical appraisal on an oral surgery, dental, or podiatric surgery patient and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. When significant medical abnormality is present the final decision on whether to proceed with surgery must be agreed upon by the oral surgeon, dentist, or podiatrist and the practitioner consultant. The Chairperson of the Surgery Service will decide the issue in case of dispute. In all instances, a practitioner member of the Medical Staff must be responsible for the care of any medical problem that may be present at admission or that may arise...
5.2.2. ADMITTING PRIVILEGES

Only Medical Staff members with clinical privileges or temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.\textsuperscript{119}

5.2.3. MEDICAL HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.\textsuperscript{120} A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.\textsuperscript{121} An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

A history and physical examination should be completed for all inpatients, ambulatory surgery patients and patients undergoing invasive procedures and/or procedural sedation.

Minimum contents of a history and physical include: History of present illness; past medical history; current medications; allergies; physical examination; impression and plan of care.

The history and physical examination with the pre-procedure/surgery update, must be on the medical record prior to operative and invasive procedures, and/or procedural sedation.

An interval history and physical is acceptable for use in cases when a patient is readmitted within 30 days for the same or related problems.

The organized medical staff will monitor the quality of medical histories and physical examinations.

5.2.4. ADDITIONS TO OR INCREASES IN CLINICAL PRIVILEGES/PRACTICE PARAMETERS

A request by an individual with clinical privileges/practice parameters for additional clinical privileges/practice parameters or an increase in clinical privileges/practice parameters may be made at any time, but such requests must

\textsuperscript{119} MS.03.01.01; MS.06.01.07, MS.06.01.13
\textsuperscript{120} MS.01.01.01, 42 C.F.R.§482.22(c)(5)(i)
\textsuperscript{121} 42 C.F.R.§482.22(c)(5)(i)
be supported by documentation of training and/or experience supportive of the request. The following documentation shall be included with any requests for an increase in clinical privileges/practice parameters and new clinical privileges/practice parameters:

5.2.4.1. Any additional license, certification or registration required for the new clinical privileges/practice parameters or increased clinical privileges/practice parameters requested shall be verified.\(^{122}\)

5.2.4.2. Training, continuing education, and experience related to the new clinical privileges/practice parameters or increased clinical privileges/practice parameters requested shall be verified.\(^{123}\)

5.2.4.3. Evidence of current competence related to the new clinical privileges/practice parameters or increased clinical privileges/practice parameters requested shall be verified. This shall include a review of relevant practitioner-specific performance data when available.\(^{124}\)

5.2.4.4. An evaluation provided by peers of the applicant shall be included in deliberations when adding or increasing privileges/practice parameters. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.\(^{125}\)

5.2.4.5. Applicants are required to report malpractice insurance coverage information for the new privileges/practice parameters or increased clinical privileges/practice parameters requested, and claims history shall be evaluated to determine any evidence of an unusual pattern or excessive number of claims.\(^{126}\)

5.2.4.6. The hospital shall query the National Practitioner Data Bank (NPDB) when new clinical privileges/practice parameters or increased clinical privileges/practice parameters are requested.\(^{127}\)

5.2.4.7. When adding or increasing clinical privileges/practice parameters the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges/practice parameters being requested and health status shall be verified.\(^{128}\)

5.2.4.8. When adding or increasing clinical privileges/practice parameters the applicant shall be required to respond to queries regarding whether there have been any:

5.2.4.8.1. Previously successful or currently pending challenges, or voluntary or involuntary relinquishment, of licensure or

\(^{122}\) MS.06.01.05
\(^{123}\) MS.12.01.01
\(^{124}\) MS.06.01.05
\(^{125}\) MS.06.01.05
\(^{126}\) MS.06.01.05
\(^{127}\) MS.06.01.05; 42 U.S.C. §11135, C.F.R. §60.10
\(^{128}\) MS.06.01.05
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5.2.4.8.2. Voluntary or involuntary reduction in privileges/practice parameters or termination of privileges/practice parameters or membership/status.

5.2.4.8.3. Involvement in any liability actions, including any final judgments or settlements.

5.2.5. BASIS FOR PRIVILEGE/PRACTICE PARAMETER DETERMINATION

There shall be criteria for granting, renewing or revising clinical privileges/practice parameters that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges/practice parameters requested. Applications and requests for clinical privileges/practice parameters shall be evaluated on the basis of the applicant’s education, training, current competence, the ability to perform the clinical privileges/practice parameters requested, professional references and peer recommendations that include written information about the applicant’s medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and health status as related to ability to perform the privileges/practice parameters requested, information from the applicant’s current or past facility affiliations regarding membership status and current competence, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Department/Section in which the privileges have been sought. The criteria for granting clinical privileges/practice parameters shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients. Clinical privileges/practice parameters that are granted, renewed, or revised shall be appropriate to the scope of services and service capabilities of the Hospital, meaning that in approving privileges/parameters, considerations shall include not only the applicant’s qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Board of Trustees to only certain settings within the Hospital, as appropriate to each setting.

The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of ongoing professional practice evaluation as provided for in Article Three of these Bylaws.
Additionally, all individuals with delineated clinical privileges/practice parameters should participate in continuing education as related to their privileges, and the applicant’s participation in continuing education shall be considered when renewing or revising such privileges/practice parameters.

Before clinical privileges/practice parameters are granted, renewed, or revised by the Board of Trustees, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:

5.2.5.1. For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of records, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;

5.2.5.2. For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;

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

5.2.5.4. Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;

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

5.2.5.6. Relevant practitioner-specific data that are compared to aggregate data;

5.2.5.7. Morbidity and mortality data, when available;

5.2.5.8. Practitioner’s use of consultants;

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

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

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

5.2.7. LOCUM TENENS PRIVILEGES

Clinical privileges may be granted to a Practitioner qualified as described in Article Three, Section 3.1, who plans to practice within the Hospital on an intermittent or substitute basis. Unless requested, a locum tenens Practitioner shall not be granted medical staff membership. The locum tenens Practitioner shall be credentialed as described in Article Three, and if qualified may be granted requested delineated clinical privileges for a period limited to the time during which the Practitioner is serving as a substitute for a Medical Staff Member, or for the time of intermittent coverage, but in no case shall the term of privileges be greater than two years from the date the clinical privileges were approved. The locum tenens Practitioner may be eligible for temporary privileges in accordance with Section 5.3 of these Bylaws if requesting privileges to provide care, treatment, or services in response to an immediate important patient care need, or after submitting a complete application with no adverse information while the application awaits approval by the Medical Executive Committee and the Board. The locum tenens Practitioner shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, including requirements for focused professional practice evaluation and ongoing professional practice evaluation, and rights to a fair hearing.

If a practitioner is serving as a Locum Tenens in Kansas they must contact the Health Care Stabilization Fund Compliance Section to ensure compliance with the Health Care Provider Insurance Availability Act. Practitioners who are granted Locum Tenens privileges must provide a signed Declaration of Compliance form to the Health Care Stabilization Fund which confirms that they will provide the required level of primary coverage and are aware that they are responsible for any and all Kansas prior acts. A primary policy with coverage exceeding the basic required limits does not exempt a practitioner from participation in the Fund.

5.2.8. PRIVILEGES TO SUPPORT POST-RESIDENCY/FELLOWSHIP SURGICAL TRAINING

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

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

5.2.8.2 Preceptee/trainee: A surgeon/physician with appropriate basic knowledge and experience seeking individual training in skills and/or procedures not learned in prior formal training. The trainee must have appropriate background knowledge, basic skills, and clinical experience relevant to the proposed curriculum. The trainee should be board-eligible as defined in these Bylaws or certified in the appropriate specialty or possess equivalent board certification from outside the United States.

5.2.9. NEW/TRANSPECIALTY PRIVILEGES

Prior to accepting request of a privilege, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame. Hospital leaders shall determine whether sufficient space, equipment, staffing, and financial resources are in place or will be available within a specified time frame to support each privilege. The clinical privileges available for request shall be approved by the Board of Trustees, based on this determination of hospital leaders. Any request for clinical privileges that are either new to the Hospital or that overlaps more than one Department/Section shall initially be reviewed by the Credentials Committee. The Credentials

143 MS.06.01.01
144 MS.06.01.01
Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transspecialty procedure, with the input of all appropriate Department/Sections, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege. In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Department/Sections or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Department/Sections, or from outside sources such as professional literature or specialty associations. The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board shall be based in part on whether the new procedure or service is appropriate to the Hospital.

5.2.10. CLOSING/DISCONTINUING A SERVICE OR ENTERING AN EXCLUSIVE CONTRACT

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

5.2.11. TELEMEDICINE PRIVILEGES

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

In addition to meeting all other qualification for clinical privileges, the following credentialing procedures shall be followed:

5.2.11.1. When a telemedicine provider is providing services from a different State, licensure will be verified for both Kansas and the State where the practitioner is located\textsuperscript{150}

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

5.2.12. USE OF OUTPATIENT DIAGNOSTIC SERVICES BY NON-PRIVILEGED PRACTITIONERS

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

5.2.12.1. The non-privileged Practitioner shall provide proof of current licensure, in Kansas, which shall be verified by the Hospital, or provide proof of being an active duty military Practitioner who is acting within the scope of military duties and providing care to a member of the military or a military dependant;\textsuperscript{151}

5.2.12.2. The Hospital shall ensure that the non-privileged Practitioner is eligible to participate in Federal and State Health Programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and the exclusion lists shall be rechecked according to the frequencies defined by hospital policy;\textsuperscript{152}

5.2.12.3. Orders may not be accepted from a non-privileged APP who, per State laws and regulations, must practice only under the supervision or sponsorship of a physician or other licensed independent practitioner (LIP),

5.2.12.4. The non-privileged Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order, as established by State law. The orders shall be confined to those for outpatient laboratory, radiology, diagnostic cardiopulmonary or electrodiagnostic testing (e.g., PFT, ECG, EEG). Examples of orders or types of patient care, treatment or services that can be provided only by a credentialed practitioner and therefore is not appropriate for a non-privileged Practitioner include, but are not limited to:

5.2.12.4.1. Admitting a patient, whether for inpatient care or same day procedures;

\textsuperscript{150} 42 C.F.R. §482.26(c)(1), Interpretive Guidelines
\textsuperscript{151} 42 C.F.R. §482.11(c), HCA, Ethics & Compliance Policy QM.002
\textsuperscript{152} HCA, Ethics & Compliance Policy QM.002
5.2.12.4.2. Serving as a Hospital patient’s attending physician;

5.2.12.4.3. Performing history & physical examinations, assessing a patient’s progress while in the Hospital, performing consultations, or preparing discharge summaries;

5.2.12.4.4. Ordering or performing surgery or any other invasive procedures, including any invasive procedures done for diagnostic testing purposes;

5.2.12.4.5. Providing on-call coverage for a privileged Practitioner;

5.2.12.4.6. Serving as a proctor or trainer, or receiving training or proctoring for professional practice;

5.2.12.4.7. Prescribing medications to be administered to a patient by Hospital personnel;

5.2.12.4.8. Prescribing medications to be dispensed by the Hospital for a patient to self-administer at home, unless the pharmacy of the Hospital is licensed for retail dispensing;

5.2.12.4.9. Issuing orders for therapeutic services; and,

5.2.12.4.10. Performing any other patient care, treatment or services for which clinical privileges must first be granted.

5.2.12.5. The order must be of a type that can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering non-privileged Practitioner.

5.2.12.6. The ordering non-privileged Practitioner does not hold himself to be associated or affiliated with the Hospital or its Medical Staff.

5.2.12.7. The non-privileged Practitioner’s ordering practices shall be subject to the supervision of the medical director of the Hospital Department/Section performing the test or service, or the Medical Staff President. The non-privileged Practitioner’s ordering practices shall be subject to a review for medical appropriateness and necessity. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the non-privileged Practitioner shall be notified immediately to be given the opportunity to clarify/justify the order.

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

5.2.13. UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege/practice parameter is not available at the
Hospital, the request shall be determined to be ineligible. Because such ineligibility is unrelated to the applicant’s qualifications or competence, an applicant whose request is deemed ineligible shall not be entitled to the Fair Hearing and Appeal rights under these Bylaws and is not subject to reporting to the National Practitioner Data Bank via the state professional licensure agency.

5.3. TEMPORARY PRIVILEGES/PRACTICE PARAMETERS

Temporary clinical privileges/practice parameters shall be granted only to individuals defined as Practitioners in these Bylaws or to APPs as defined in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff or currently privileged APPs. Therefore, temporary privileges/practice parameters shall be granted only rarely. In granting temporary privileges/practice parameters, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner or APP exercising such privileges/parameters. A Practitioner or APP shall not be entitled to the procedural rights of fair hearing or appeal afforded by these Bylaws because of his/her inability to obtain temporary privileges/parameters or because of any termination of temporary privileges/parameters.

5.3.1. QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this State, (except for educational purposes as outlined in Temporary Privileges for Educational Purposes Wesley Galichia Heart Hospital Administrative Policy) a current and unrestricted DEA registration reflecting an in-state address for the State of Kansas (if the practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, documentation of professional liability insurance coverage as required by the Board except as specified in Section 5.3.2.3 in this Article, and for Practitioners a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care. Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source, and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant’s status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall check the OIG Sanction Report, and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, Department/Sectional rules and regulations, and applicable Hospital policies.

5.3.2. CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY
PRIVILEGES/PRACTICE PARAMETERS

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

5.3.2.1. Pendency of Application: After receipt of complete application for Medical Staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Article Five, Section 5.3.1 may be granted temporary while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days. An applicant waiting for processing of an application for Medical Staff membership shall be eligible for temporary privileges only after submitting a complete application and only under the following conditions:

5.3.2.1.1. There are no current or previously successful challenges to licensure or registration;
5.3.2.1.2. There are no adverse membership actions at another hospital;
5.3.2.1.3. There are no adverse actions against the applicant’s privileges at another hospital;
5.3.2.1.4. No more than two (2) malpractice cases currently on file, and no more than three (3) cases total. This condition may be waived by the Credentials Committee for good cause shown by the applicant;
5.3.2.1.5. No unfavorable peer, education or organization references.

5.3.2.2. Care of Specific Patient(s): Temporary privileges/practice parameters may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein. After receipt of a written request for temporary

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157 MS.06.01.13
158 MS.06.01.13
159 HCA, Ethics & Compliance Policy QM.002
160 MS.06.01.07, MS.08.01.03
161 MS.06.01.13
162 MS.06.01.13
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privileges/practice parameters, a Practitioner or APP qualified as described in Article Five, Section 5.3.1 may be granted temporary privileges/practice parameters if the Practitioner or APP has a specific skill not possessed by a privileged Practitioner or APP, and the specific skill is needed by a specific patient or specific group of patients, authorization may be granted to provide care for that specific patient or group of patients. Temporary privileges/practice parameters granted under this condition shall not exceed the length of stay of the specific patient(s) or one hundred and twenty (120) consecutive days, whichever is less.\textsuperscript{163} A Practitioner or APP may be granted temporary privileges/practice parameters under this condition for no more than two instances in a twelve-month period. After a Practitioner or APP has been granted temporary privileges/practice parameters under this condition for the second instance within twelve months, he/she shall be required to apply for Medical Staff/APP membership and/or clinical privileges/practice parameters before providing additional patient care, treatment or services at the Hospital.

5.3.2.3. Disaster Response and Recovery:\textsuperscript{164} Potential disaster situations shall be described in the Hospital Emergency Operations Plan\textsuperscript{165} and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster. Upon activation of the Hospital’s Emergency Operations Plan and in a situation in which the Hospital is not able to meet immediate patient needs,\textsuperscript{166} temporary disaster privileges may be granted to an appropriately qualified Practitioner as described in Article Five, Section 5.3.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan (EOP), upon recommendation by the Medical Staff President or the EOP designated Medical Staff Director.\textsuperscript{167} All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs.\textsuperscript{168} Approvals shall be documented in writing. The Medical Staff President or the EOP designated Medical Staff Director shall also assign a Member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges, through direct observation, mentoring, or clinical record review.\textsuperscript{169} Practitioners who are employees of any Federal agency, and Practitioners acting on

\textsuperscript{163} MS.06.01.13
\textsuperscript{164} EM.02.02.13
\textsuperscript{165} EM.02.01.01
\textsuperscript{166} EM.02.02.13
\textsuperscript{167} EM.02.02.13
\textsuperscript{168} EM.02.02.13
\textsuperscript{169} EM.02.02.13
behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less. In the event that the disaster creates extreme urgencies as defined in Section 5.4, a Practitioner would be permitted to provide patient care using emergency privileges.

5.3.2.3.1. Temporary disaster privileges may be granted upon presentation of a government-issued photo identification and any of the following, and the qualifications required in Section 5.3.1 of this Article shall be verified as soon as the immediate disaster situation is under control, using a process identical to granting temporary privileges for an immediate patient care need, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the organization, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours.

5.3.2.3.1.1. A current picture identification card from a healthcare organization that clearly identifies professional designation;  
5.3.2.3.1.2. A current license to practice;  
5.3.2.3.1.3. Primary source verification of the license;  
5.3.2.3.1.4. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group;  
5.3.2.3.1.5. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,  
5.3.2.3.1.6. Presentation by a current hospital or medical

170 28 U.S.C. §2671; 42 U.S.C. §233(a),(g)  
171 MS.06.01.13  
172 EM.02.02.13  
173 EM.02.02.13
staff Member(s) with personal knowledge regarding the practitioner’s identity.

5.3.2.3.2. The following order of preference should be used in granting temporary disaster privileges:

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

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

5.3.2.3.2.3. Volunteers from the community or surrounding areas.

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

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

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

5.3.2.3.6. The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the Medical Staff President or the EOP designated Medical Staff Director. In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated.
When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.

5.4. EMERGENCY PRIVILEGES

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

6. CORRECTIVE ACTIONS

6.1. CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical,\(^{178}\) (3) unprofessional, inappropriate, disruptive or harassing, (as defined in these Bylaws and in Hospital policies, including sexual harassment),\(^{179}\) (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below applicable professional standards, the Medical Staff President/CMO, appropriate Department/Section Chairperson, Credentials Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible. A determination will then be made as to whether to refer the matter to the Medical Executive Committee or to deal with the matter in accordance with the relevant Medical Staff policy. If it is determined to direct the matter to the Medical Executive Committee, a written request for investigation shall be prepared, making specific reference to the performance information, activity or conduct that gave rise to the request. The investigation shall be conducted pursuant to the peer review provisions in these Bylaws.\(^{180}\)

6.2. COLLEGIAL INTERVENTIONS

These Bylaws encourage the use of progressive steps by medical staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective actions.

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\(^{178}\) HCA Ethics & Compliance Policies

\(^{179}\) HCA Ethics & Compliance Policies

\(^{180}\) MS.01.01.01
action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws or the Medical Center’s Risk Management Plan.

6.2.1. Collegial intervention is a part of the Hospital's professional review activities and may include, but is not limited to, the following:

6.2.1.1. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

6.2.1.2. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.21 that may be taken to address unprofessional or inappropriate conduct;

6.2.1.3. Proctoring, monitoring, consultation, and letters of guidance;

6.2.1.4. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;

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

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

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

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

6.2.1.9. Requirements to seek assistance for a health issue, as provided in these Bylaws.¹⁸¹

6.2.2. The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer/CMO, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy, Risk Management Plan) or should be referred to the MEC for further action.

6.2.3. The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's peer review file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

6.3. PRECAUTIONARY SUSPENSION OR PRECAUTIONARY RESTRICTION OF CLINICAL PRIVILEGES

6.3.1. Grounds for Precautionary Suspension or Restriction:

6.3.1.1. Whenever a practitioner or other individual with clinical privileges willfully disregards these Bylaws or the Medical Staff Rules &

¹⁸¹ MS.11.01.01
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Regulations or Hospital Policies, or whenever his/her conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the hospital, or to prevent interference with the orderly operation of the Hospital, the Medical Staff President, the chief of a clinical Department/Section, the Chief Executive Officer, the Board Chairperson, or the Medical Executive Committee shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.

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

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

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

6.3.2. Reporting Requirement:

6.3.2.1. In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual’s privileges for more than thirty (30) days. The State of Kansas states that within thirty (30) days following any termination, suspension or restriction of clinical privileges or a voluntary surrender of clinical privileges for reasons related to the competence of a practitioner licensed by the Kansas Board of Healing Arts, a report regarding same will be submitted to the licensing board.

6.3.3. Medical Executive Committee Procedure:
6.3.3.1. As soon as possible after such precautionary suspension, but no longer than fourteen (14) calendar days after imposition, the Medical Executive Committee shall be convened to review the matter resulting in a precautionary suspension or restriction and consider the action taken. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

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

6.3.4. Reporting Requirement:

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

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

6.4. INVESTIGATION/PEER REVIEW PROCESS

6.4.1. Initiation of Investigation:

6.4.1.1. When a question involving clinical competence or professional conduct is referred to, or raised by the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled by a person or committee appointed by the MEC or pursuant to another policy, such as the practitioner health issues policy; peer review policy, or to proceed in another manner. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Medical Executive Committee to do so.

6.4.1.2. The Medical Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

6.4.1.3. The Board of Trustees may also determine to commence an investigation
and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board of Trustees, or an ad hoc committee.

6.4.1.4. The Medical Staff President/CMO shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

6.4.2. An investigation may be initiated in response to the circumstances in a single case, or to investigate a pattern or trend in performance. The investigation may involve an interview with the Practitioner and/or an interview of other individuals or groups deemed appropriate by the investigating body. If a coincidental investigation is being or has been conducted pursuant to the Medical Center’s Risk Management Plan, as described in paragraph 6.6 of this Section, findings from that investigation may be considered and adopted. External third parties may be utilized to assist with the investigation process as necessary. Standard of Care is assigned by the Chair of the Section, to which the practitioner is assigned, or by the Medical Director of the department, to which the practitioner is assigned, or by the Chief Medical Officer. A SOC 3 or 4 are referred to the Medical Executive Committee. If a conflict arises between the section/department Medical Director/CMO and the peer review committee regarding the SOC assigned, will be forwarded to the MEC to determine SOC. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as practical after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board of Trustees, terminate the investigation process and proceed with action as provided below. The investigation procedures do not constitute a hearing and need not be conducted in accordance with the formal procedures for a fair hearing.

6.4.3. The investigation shall include:

6.4.3.1. Conformance to the peer review procedures outlined in Article Ten.

6.4.3.2. As deemed necessary by the investigating body, a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information material to the matter being investigated;

6.4.3.3. A report of the investigation, including all material evidence, and a recommendation to the Medical Executive Committee.

6.5. **ACTION ON INVESTIGATION REPORT**

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

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

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

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

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, upon confirmation of the circumstances by the Chief Executive Officer, the individual shall be immediately and automatically suspended from practicing in the Hospital by the Chief Executive Officer, and the individual’s membership may be automatically terminated. The Chief Executive Officer shall notify the individual in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice.\(^{182}\) The Chief Executive Officer shall also notify the Medical Staff President and Hospital staff members, and take necessary steps to enforce the suspension.

6.6.1. The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

6.6.1.1. **Licensure**

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

6.6.1.2. **Controlled Substance Registration**

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

6.6.1.3. **Liability Insurance**

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

6.6.1.4. **Eligibility to Participate in Federal Programs**

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

6.6.1.4.1. Becoming an Ineligible Person;\(^{183}\) or,

6.6.1.4.2. A criminal conviction.

6.6.1.5. **Medical Records**

A medical record is considered to be delinquent when it has not been

\(^{182}\) MS.01.01.01

\(^{183}\) HCA, Ethics & Compliance Policy QM.002

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completed for any reason within thirty (30) calendar days following a patient’s discharge.

A delinquent episode is defined as the failure to complete one or more medical records greater than 30 days old from date available or failure to complete one or more key documents with required completion within 24 hours of event

- History & Physical/Operative Report will be delinquent within 24 hours
- All verbal/telephone orders will be authenticated, signed/timed/dated, by the prescribing/covering practitioner within 72 hours of the patient’s discharge or 30 days, whichever occurs first.

When a Medical Staff Member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, following notification, his/her clinical privileges shall be automatically suspended. The suspension shall continue until all of the individual’s delinquent records are completed.

6.6.1.5.1 Photocopy Request for Medical Records

A practitioner for whom corrective action has been initiated is entitled to a photocopy of the patient(s) records involved in the corrective action, subject to the provisions of this section. All requests for copies of medical records shall be in writing and include at a minimum patient’s demographic information (i.e. full name, date of birth, date of service); portion(s) of record needed for review, and requestors name and address, and purpose for request). Patient authorization is not required for risk management/peer review photocopy requests in accordance to both Kansas Risk Management Law and Health Insurance Portability and Accountability Act (HIPAA).

Wesley Medical Center will provide one (1) courtesy copy of the involved patient(s) records at no fee to the practitioner. The Kansas photocopy fee for all additional copies will be invoiced to the practitioner.

Medical records may be reviewed within the Health Information Management Department/Section during normal business hours. Medical records shall not be delivered to a physician’s office for review of potential corrective action investigation, preparation for deposition, or other risk matters.

Refer to Wesley Administrative Policy E53.2 for guidelines to document an addendum, late entry, or make corrections to the
6.6.1.6. Misrepresentation

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

6.6.2. Reporting Requirement

6.6.2.1. In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual’s privileges for more than thirty (30) days. Within thirty (30) days following any termination, suspension or restriction of clinical privileges or a voluntary surrender of clinical privileges for reasons related to the competence of a practitioner licensed by the Kansas Board of Healing Arts, a report regarding same will be submitted to the licensing board.

6.7. COVERAGE DURING SUSPENSIONS

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

6.8. FAILURE TO PROVIDE REQUESTED INFORMATION

Failure of an individual to provide information pertaining to that individual’s qualifications for Medical Staff membership or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer/CMO, or any other committee authorized to request such information within thirty (30) days in the written request, will result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

6.9. CRIMINAL ARREST OR INDICTMENT

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

6.10. REINSTATEMENT FOLLOWING A SUSPENSION

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

6.11. AUTOMATIC RESIGNATION

6.11.1. Relocation

Unless otherwise approved by the Board upon recommendation of the Medical Executive Committee, any Member of the staff or other individual with clinical privileges who takes up permanent residence more than thirty (30) miles from the Hospital shall be deemed to have resigned from the Staff and relinquished all clinical privileges.

A practitioner must practice and/or reside within 30 miles of the medical center. This requirement does not apply for practitioners who provide services contractually with the medical center by way of electronic communication (telemedicine)

The physician must be available to respond for patient care within 30 minutes.

6.11.2. Failure to Apply for Reappointment or Renewal of Privileges

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two years (24 months). In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated. The individual shall be notified of the termination and the need to submit a new application if continued membership or clinical privileges are desired.184

6.11.3. Failure to be Reinstated Following Automatic Suspension

184 MS.06.01.07

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

7. HEARING AND APPELLATE REVIEW PROCEDURES

7.1. OVERVIEW

Fair hearing and appellate review procedures shall be used when professional review actions are being taken when it involves an individual applying for Medical Staff membership, for an existing Medical Staff Member, and for any other individual applying for or holding clinical privileges. The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Professional review actions are taken when there is a reasonable belief that the action shall be in the furtherance of quality healthcare, and after a reasonable effort to obtain the facts of the matter, and in reasonable belief that the action is warranted by the facts, and after adequate notice and hearing procedures and other procedures as are fair to the individual are afforded to the individual subject to professional review actions. Individuals with practice parameters who are not applying for Medical Staff membership and who are not Medical Staff members are not afforded a fair hearing and appeal process. The hearing procedures for individuals with practice parameters who are not applying for Medical Staff membership and who are not Medical Staff members is described in Article Seven, Section 7.9.4 of these Bylaws.

7.2. EXCEPTIONS TO HEARING AND APPEAL RIGHTS

7.2.1. COLLEGIAL ACTIONS

The practitioner does not have a right to a hearing in any of the following circumstances when collegial action(s) is taken, or when an adverse action is recommended but not taken:

7.2.1.1. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

7.2.1.2. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.21 that may be taken to address unprofessional or inappropriate conduct;

185 42 USCS §11112(a)(1) – (4)
186 MS.10.01.01
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7.2.1.3. Proctoring, monitoring, consultation, and letters of guidance;

7.2.1.4. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;

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

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

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

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

7.2.1.9. Requirements to seek assistance for a health issue, as provided in these Bylaws.

7.2.1.10. A request for an adverse action involving the practitioner that has been recommended but denied.

7.2.2. AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT PLAN

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

7.2.3. MEDICO-ADMINISTRATIVE OFFICER/CMO OR OTHER CONTRACT PRACTITIONER

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

7.2.4. AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES

The hearing and appeal rights under these Bylaws do not apply if an individual’s Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws for reasons not
related to the Practitioner’s qualifications, competence or professional conduct.

7.2.5. REMOVAL FROM EMERGENCY CALL PANEL

Participation on the emergency on-call panel is not a benefit or privilege of Staff membership, but rather is an obligation. No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner’s emergency on-call panel obligation(s), unless it is an adverse event as defined in these bylaws.

7.2.6. HOSPITAL POLICY DECISION

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

7.2.7. ADMINISTRATIVE ACTIONS

A practitioner does not have the right to a hearing in any of the following circumstances:

7.2.7.1. Change to specific medical staff membership prerogatives (as examples: voting privileges, eligibility for committee membership, eligibility to hold office, etc.) if the reasons are unrelated to professional competence or conduct;

7.2.7.2. Actions taken due to failure to attend meetings as required;

7.2.7.3. Denial, termination or reduction of temporary privileges if the reasons are unrelated to professional competence or conduct;

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

7.2.7.5. Any other actions except those listed in Section 7.3.

7.3. HEARING RIGHTS

7.3.1. ADVERSE RECOMMENDATIONS OR ACTIONS

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

7.3.1.1. Denial of initial staff appointment;

7.3.1.2. Denial of reappointment;

7.3.1.3. Suspension of staff membership;

7.3.1.4. Revocation of staff membership;

7.3.1.5. Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations;
7.3.1.6. Denial of requested clinical privileges;
7.3.1.7. Involuntary reduction in clinical privileges;
7.3.1.8. Precautionary suspension or restriction of clinical privileges, as defined in Article Six;
7.3.1.9. Revocation of clinical privileges; or,
7.3.1.10. Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to provisional status or the granting of new privileges).

7.3.1.11 Standards of Care (SOC) III - Standards of care not met, with injury occurring or reasonably probable.

7.3.1.12 Standards of Care (SOC) IV – Possible grounds for disciplinary action by the appropriate licensing agency.

7.3.2. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

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

7.3.2.1. State the reasons for an adverse recommendation or action, with enough specifics to allow response;
7.3.2.2. Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.
7.3.2.3. Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing.
7.3.2.4. State that failure to request a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to an appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Trustees.
7.3.2.5. State a summary of the Practitioner’s rights at the hearing.
7.3.2.6. State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

7.3.3. REQUEST FOR HEARING

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

7.3.4. FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.3.3 waives any right to such a hearing and to any appellate

\[188^\text{42 USCS §11112(b)(1)(A-C)}\]
\[189^\text{42 USCS §11112(b)(1)(B)(i – ii)}\]
review to which he/she might otherwise have been entitled. Such waiver in connection with:

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

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

7.4. HEARING PREREQUISITES

7.4.1. SPECIAL WRITTEN NOTICE

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

7.4.1.1. The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;\(^{190}\)

7.4.1.2. A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;\(^{191}\)

7.4.1.3. The Practitioner involved has the right: \(^{192}\)

7.4.1.3.1 To be present at the hearing;

7.4.1.3.2. The Practitioner may be accompanied and represented at the Hearing by a member of the Medical Staff. The MEC shall appoint individuals to represent it. In addition, either party may be assisted by an attorney for purposes of advice and counsel only; no attorney shall actively participate in opening or closing statements, presentation of evidence or questioning of witnesses. Attorneys cannot talk or exhibit behavior which would be disruptive to the proceedings. The Chairperson has the prerogative to ask any person to leave the proceedings.

7.4.1.3.3. To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;

7.4.1.3.4. To call, examine, and cross-examine witnesses;

7.4.1.3.5. To present evidence determined to be relevant by the Chairperson of the hearing panel, regardless of its admissibility in a court law; and,

\(^{190}\) 42 USCS §11112(b)(2)(A)

\(^{191}\) 42 USCS §11112(b)(2)(B)

\(^{192}\) 42 USCS §11112(b)(3)(i – v)
7.4.1.3.6. To submit a written statement at the close of the hearing.

7.4.1.4. Upon completion of the hearing, the Practitioner involved has the right:

7.4.1.4.1. To receive a record of the proceedings upon payment of a reasonable charge;

7.4.1.4.2. To receive the written recommendation of the hearing panel, including a statement of the basis for the recommendations; and,

7.4.1.4.3. To receive a written decision of the Board of Trustees, including a statement of the basis for the decision.

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

7.4.2. APPOINTMENT OF HEARING PANEL

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

7.4.2.2. By Board of Trustees: A hearing occasioned by an adverse action of the Board shall be conducted by a hearing panel appointed by the Chairperson of Board.

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

7.4.2.4. Challenges for Cause: The Practitioner may question hearing panel members regarding potential bias, prejudice or conflict of interest and challenge any Member of the hearing committee for any cause, which would indicate bias or predisposition. The Chairperson, or if challenged, the Medical Staff President, shall decide the validity of such challenges. His/her decision shall be final.

7.5. HEARING PROCEDURE

193 42 USCS §11112(b)(3)(D)(i – ii)
194 42 USCS §11112(b)(3)(C)(ii)
7.5.1. PERSONAL PRESENCE

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

7.5.2. PRESIDING OFFICER

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

7.5.3. APPOINTMENT OF A HEARING OFFICER OR LEGAL CONSULTANT

The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Medical Staff President. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act as the presiding officer of the hearing. The Medical Staff President may appoint an attorney to be a legal consultant to the hearing panel. The hearing officer or legal consultant may be present during deliberations, but shall not vote.

The Hearing Officer or Legal Consultant may refer to, but not be bound by, the Kansas Administrative Procedures Act.

7.5.4. REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and assisted at the hearing by an attorney or by another person of his/her choice. Either party may be assisted by an attorney for purposes of advice and counsel only; no attorney shall actively participate in opening or closing statements, presentation of evidence or questioning of witnesses. Attorneys cannot talk or exhibit behavior which would be disruptive to the proceedings. The Medical Executive Committee or the Board, depending on whose recommendation or action promoted the hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses. The Chairperson has the prerogative to ask any person to leave the proceedings.

7.5.5. RIGHTS OF PARTIES

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

7.5.5.1. Call and examine witnesses;

7.5.5.2. Introduce exhibits;

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

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195 42 USCS §11112(b)(3)(C)(i)
196 42 USCS §11112(b)(3)(C)(iii – v)
7.5.5.4. Impeach any witness;
7.5.5.5. Rebut any evidence; and
7.5.5.6. Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

7.5.6. PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing panel is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The hearing panel shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the hearing panel Chairperson’s discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

7.5.6.1. Written Submissions Prior To Commencement

The Medical Staff, Medical Center, or the practitioner may provide written information to the members of the Hearing Committee prior to commencement of the hearing for purposes of expediting the hearing. All Hearing Committee members shall be given the same information at the same time, a copy of information given to the Hearing committee shall also be given to the other parties. The Hearing committee members shall maintain all written submissions in strict confidence, and shall bring all such written material to the hearing when it commences.

7.5.6.2. Contact With Committee Prior to Commencement

With the exception of the written submissions allowed by 2.7 above, there shall be no contact by the Medical Staff, Medical Center or Practitioner or their representatives, with any member of the Hearing committee regarding the practitioner or the substantive issues involved, until the hearing commences.

7.5.7. BURDEN OF PROOF

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

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

7.5.9. POSTPONEMENT

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

7.5.10. PRESENCE OF HEARING PANEL MEMBERS AND VOTE

A majority of the hearing panel, but in no event less than three members, must be present throughout the hearing and deliberations. If a panel member is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or to vote. Only the Hearing Committee members and an administrative aide shall be present during deliberations.

7.5.11. RECESSES AND ADJOURNMENT

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

7.6. HEARING PANEL REPORT AND FURTHER ACTION

7.6.1. HEARING PANEL REPORT

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

7.6.2. ACTION ON HEARING PANEL REPORT

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

7.6.3. NOTICE AND EFFECT OF RESULT
7.6.3.1. **Notice:** The Chief Executive Officer shall promptly send a copy of the result and report to the Practitioner by special notice, to the Medical Staff President, to the Medical Executive Committee and to the Board.

7.6.3.2. **Effect of Favorable Result:**

7.6.3.2.1. **Adopted by the Medical Executive Committee:** If the Medical Executive Committee’s recommendation is favorable to the Practitioner, the Chief Executive Officer/CMO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the Medical Executive Committee’s recommendation in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons for the referral, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall within 29 days take final action. The Chief Executive Officer/CMO shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

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

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

7.6.4. **HEARING AND APPEAL PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS**

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

7.6.4.1. **Notice:** Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has 30 days in which to request a hearing. If the APP does not request a hearing within 30 days, the APP shall have waived right to a hearing.

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7.6.4.2. Hearing Panel: The Executive Committee to which the APP is a member will make up the hearing panel. The panel members shall also include the Chief Executive Officer/CMO, and a peer of the APP.

7.6.4.3. Rights: The APP subject to the adverse recommendation or action shall have the right to present information, but can not have legal representation or call witnesses.

7.6.4.4. Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination:

7.6.4.4.1. A determination favorable to the APP shall be recorded in the Executive Session minutes of the Section/Department meeting.

7.6.4.4.2. A determination adverse to the APP shall be forwarded by the Section/Department to the MEC

7.6.4.5. Final Decision: The decision of the Chairperson of the Board shall be final.

7.6.5. HEARING AND APPEAL PROCEDURES FOR RESIDENTS

Individuals with practice parameters who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e. Residents) are afforded a fair hearing and appeal process, but that process shall be a modification of that for Medical Staff members or applicants for Medical Staff membership. The following procedures shall be used for Residents:

7.6.5.1 Notice: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the Resident by the Chief Medical Officer (with a copy to the Resident’s Program Director and the KU Designated Institutional Officer) subject to the adverse recommendation or action. The notice shall state that the Resident has 10 days in which to request a hearing. If the Resident does not request a hearing within 10 days, the Resident shall have waived right to a hearing.

7.6.5.2 Hearing Panel: The Executive Committee to which the Resident is affiliated through his/her residency program, will make up the hearing panel. The panel members shall also include the Chief Executive Officer/CMO, and a peer of the Resident.

7.6.5.3 Rights: The Resident subject to the adverse recommendation or action shall have the right to present information, but cannot have legal representation or call witnesses. The KU DIO and Resident’s Program Director will select a Resident Advocate to assist the Resident through this process.

7.6.5.4 Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination;

7.6.5.4.1 A determination favorable to the Resident shall be recorded in the Executive Session minutes of the Section/Department meeting.

7.6.5.4.2 A determination adverse to the Resident shall be forwarded by the Section/Department to the MEC

7.6.5.5 Final Decision: The decision of the Chairperson of the Board shall be final

7.6.6. EXTERNAL REPORTING REQUIREMENTS

The Hospital shall submit a report to the appropriate state professional licensure
board (i.e., the state agency that issued the individual’s license to practice) and all other agencies as required by all applicable Federal and/or State law(s) and in accordance with Hospital policy and procedures.\(^{198}\)

7.7. **APPELLATE REVIEW**

7.7.1. Time for Appeal

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

7.7.2. Grounds for Appeal:

7.7.2.1. The grounds for appeal shall be limited to the following:

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

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

7.7.3. Time, Place and Notice

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

7.7.4. Nature of Appellate Review

7.7.4.1. The Board may consider the appeal as a whole body, or the Chairperson of the Board may appoint a Review Panel composed of no less than three persons, either members of the Board or others, including, but not limited to, reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

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

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\(^{198}\) 42 USCS §11133(a)

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

7.7.5. Appellate Review in the Event of Board Modification or Reversal of Hearing Panel Recommendation

7.7.5.1. If the Board determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review, and such action would adversely affect the individual, the Board shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal. The Board shall take no final action until the individual has exercised or has waived that appeal provided in these Bylaws. The Board has the final say in the matter, regardless of what the Hearing Panel recommends, as long as the decision of the Board reasonably relates to the operation of the hospital and is administered fairly.

7.7.6. Final Decision of the Board

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

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

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

7.7.7. Further Review

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

7.8. RIGHT TO ONE HEARING AND ONE APPEAL ONLY

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical
8. **MEDICAL STAFF OFFICERS**

8.1. **ELECTED OFFICERS OF THE STAFF**

8.1.1. **IDENTIFICATION**

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

8.1.2. **QUALIFICATIONS**

Officers must be members of the active staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office. To qualify for the position of Medical Staff President or Medical Staff President-Elect, a Member of the Medical Staff must be a doctor of medicine or osteopathy. Except for these specific qualification requirements, no Medical Staff Member actively practicing in the Hospital is ineligible for election to an officer position solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

- Be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years;
- Have no pending adverse recommendations concerning medical staff appointment or clinical privileges;
- Be willing to faithfully discharge the duties and responsibilities of the position;
- Have experience in a leadership position for at least two years, or other involvement in performance improvement functions;
- Attend continuing education relating to medical staff leadership and/or credentialing functions during the term of the office.

8.1.2.6 The President of the Medical Staff cannot hold simultaneously the Chairpersonship of a Clinical Service or Directorship of a Department at this medical center during his/her tenure.

8.2. **TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS**

8.2.1. **TERM OF OFFICE**

Each officer shall serve a two (2) year term. The term of office shall commence on the first day of the medical staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is

199 MS.01.01.01
200 LD.01.05.01, §482.22(b)(3)
otherwise unable to complete the term. At the end of the Medical Staff President’s term, the Medical Staff President-Elect shall automatically assume that office and the Medical Staff President shall automatically serve as the Immediate Past Medical Staff President.\textsuperscript{201}

8.2.2. ELIGIBILITY FOR RE-ELECTION

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

8.3. ATTAINMENT OF OFFICE

8.3.1. NOMINATION

At least ninety (90) days before the annual Staff meeting of each even-numbered year, the Nominating Committee shall convene and submit to the Medical Staff President one or more qualified nominees for the offices of Medical Staff Secretary-Treasurer. The Nominating Committee shall report the names of the nominees to the Staff at least sixty (60) days before the annual meeting. Nominations may also be made by petition signed by at least ten percent of the appointees of the active staff, with a signed statement of willingness to serve by the nominee, filed with the Medical Staff President at least forty-five (45) days before the annual meeting. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Nominating Committee shall submit one or more additional nominees at the annual meeting and nominations may be accepted from the floor if the nominee is present at the meeting and consents to the nomination.

8.3.2. ELECTION

Voting at the annual meeting shall be by secret written ballot, and mailed ballots may be counted. Written ballots shall include signatures for comparison with signatures on file, when necessary. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held at the meeting by secret written ballot. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.\textsuperscript{202}

8.3.3. BOARD RATIFICATION/INDEMNIFICATION

\textsuperscript{201} MS.01.01.01
\textsuperscript{202} MS.01.01.01
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To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department/Section and Division officers, who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment/performance improvement activities. The Board’s ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assessment/performance improvement activities. Such activities shall have the following characteristics:

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

8.3.3.2. The activities shall be performed in good faith,

8.3.3.3. That any professional review action shall be taken:

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

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

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

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

8.3.3.4. The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;

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

8.4. VACANCIES

8.4.1. WHEN CREATED

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

8.4.2. OFFICE OF THE MEDICAL STAFF PRESIDENT

203 42 USCS §11111
204 NOTE: Legal Reasons for Board Ratification of Medical Staff Officers:

Board ratification is a critical step in making clear that, when performing credentialing and performance improvement activities, medical staff leaders are acting as agents of the hospital. As agents of the hospital, they are covered under the hospital’s Directors’ and Officers’ insurance. Board ratification maximizes the legal protections offered under federal and state law. At the same time it minimizes the likelihood that medical staff leaders will be named as defendants in an antitrust suit brought by a physician unhappy with their assessments or recommendations. It takes two entities to conspire - agents of the same entity do not have the legal capacity to conspire.

205 42 USCS §11112(a)(1-4)
When a vacancy occurs in the office of the Medical Staff President, then the Medical Staff President-Elect shall serve the remaining term of the former Medical Staff President. The vacancy then created in the office of Medical Staff President-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Medical Staff President and Medical Staff President-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the Board shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

8.4.3. MEDICAL STAFF OFFICERS OTHER THAN THE MEDICAL STAFF PRESIDENT

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

8.5. RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

8.5.1. RESIGNATION

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

8.5.2. REMOVAL

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

8.5.2.1. Failure to perform the duties of office;
8.5.2.2. Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;
8.5.2.3. Failure to support the compliance of the Hospital and the Medical Staff with applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;
8.5.2.4. Failure to maintain qualifications for office, specifically, failure to
maintain active staff status in good standing; and/or,

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

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board of Trustees prior to a vote on removal.

8.5.3. RECALL FROM OFFICE

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

8.6. RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS

8.6.1. MEDICAL STAFF PRESIDENT

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

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

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

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

8.6.1.4. Appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Board;

8.6.1.5. Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies, implement sanctions when indicated,

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207 MS.01.01.01
208 LD.01.05.01; 42 C.F.R. §482.22(b)(3)
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8.6.1.6. Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;

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

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

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

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

8.6.1.11. Recommend clinical privileges for each Member of the Medical Staff or other individual requesting clinical privileges. If the Medical Staff President is in direct economic competition with the applicant, then the Medical Staff President should not participate in the decision, but should delegate this responsibility to the Medical Staff President Elect.

8.6.1.12. Conduct surveillance of the professional performance of all individuals who have clinical privileges.

8.6.2. MEDICAL STAFF PRESIDENT-ELECT

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

8.6.3. SECRETARY-TREASURER

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

8.6.3.1. Maintain a roster of Medical Staff members;

8.6.3.2. Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;

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

8.6.3.4. Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff; and,
8.6.3.5. Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority.

8.6.4. IMMEDIATE PAST MEDICAL STAFF PRESIDENT

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

8.7. CHIEF MEDICAL OFFICER

The Chief Medical Officer shall be a physician who is employed or under contract with the Hospital to perform administrative duties related to the medical staff affairs of the Hospital. The Chief Medical Officer is not elected by the Medical Staff and therefore is not one of the officers of the Medical Staff organization. The Chief Medical Officer is a Medico-Administrative Officer, and as such, the provisions of Article Three, Section 3.16 of these Bylaws apply.

8.7.1. QUALIFICATIONS

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

8.7.2. RESPONSIBILITIES AND AUTHORITY

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

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

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

8.7.2.3. Serve as an ex-officio Member of all Medical Staff committees, without vote, except for a practicing physician in department/service they are a member.

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

8.7.3. APPOINTMENT

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

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

9. **CLINICAL DEPARTMENT/SECTIONS AND SPECIALTY DIVISIONS**

9.1. **DESIGNATION**

9.1.1. **CURRENT CLINICAL DEPARTMENT/SECTIONS**

The Medical Staff shall be organized into clinical Department/Sections. The Medical Staff Department/Sections are:\(^{211}\)

9.1.1.1. Internal Medicine
9.1.1.2. Family Medicine
9.1.1.3. Surgery
9.1.1.4. Obstetrics/Gynecology
9.1.1.5. Pediatrics
9.1.1.6. Anesthesia
9.1.1.7. Pathology
9.1.1.8. Emergency Medicine
9.1.1.9. Radiology
9.1.1.10. Orthopedics
9.1.1.11. Cardiology

9.1.2. **SPECIALTY DIVISIONS WITHIN A DEPARTMENT/SECTION**

Each Department/Section may be further subdivided into specialty Divisions. The Divisions are:\(^{212}\)

9.1.2.1. Internal Medicine Service
   9.1.2.1.1. Internal Medicine; Allergy; Medical Oncology; Nephrology; Dermatology; Neurology; Endocrinology-Metabolism; Psychiatry; Gastroenterology; Pulmonary Medicine; Hematology; Rheumatology; Infectious Diseases

9.1.2.2. Family Medicine Service
   9.1.2.2.1. Family Medicine

9.1.2.3. Surgery Service
   9.1.2.3.1. Abdominal; Otorhinolaryngology; Cardiovascular; Plastic Surgery; Proctology; Neurosurgery; Thoracic; Ophthalmology; Traumatic; Oral Surgery; Urology

9.1.2.4. Obstetrics/Gynecology Service
   9.1.2.4.1. Obstetrics; Gynecology; Maternal-Fetal Medicine; Urogynecology

9.1.2.5. Pediatrics Service
   9.1.2.5.1. Pediatrics; Neonatology

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\(^{211}\) MS.01.01.01, MS.06.01.07, LD.04.01.05

\(^{212}\) MS.01.01.01, MS.06.01.07, LD.04.01.05

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9.1.2.6. Anesthesia Service
   9.1.2.6.1. Anesthesia; Pain Management
9.1.2.7. Pathology Service
   9.1.2.7.1. Pathology
9.1.2.8. Emergency Medicine
   9.1.2.8.1. Emergency Medicine
9.1.2.9. Radiology
   9.1.2.9.1. Radiology
9.1.2.10. Orthopedics
   9.1.2.10.1 Orthopedics; Podiatry

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

9.3. REQUIREMENTS FOR AFFILIATION WITH DEPARTMENT/SECTIONS AND DIVISIONS
Each Medical Staff Member and other individuals with clinical privileges shall be assigned to one Department/Section by the Board based on recommendations from the Medical Executive Committee. A Member or other individual with clinical privileges may be granted clinical privileges in one or more other Department/Sections. The exercise of clinical privileges within any Department/Section shall be subject to the rules and regulations of the Department/Section and the authority of the Department/Section Chairperson.

9.4. FUNCTIONS OF DEPARTMENT/SECTIONS
The Department/Sections shall meet at least quarterly to perform the following functions:
9.4.1. CLINICAL FUNCTIONS
   9.4.1.1. Serve as a forum for the exchange of clinical information regarding services provided by Department/Section members;
   9.4.1.2. Provide recommendations to the Department/Section Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department/Section members;
   9.4.1.3. Provide recommendations to the Department/Section Chairperson regarding professional criteria for clinical privileges designed to assure the Medical Staff and Board that patients shall receive quality care.\(^{213}\) The
recommendations shall include:

9.4.1.3.1. Criteria for granting, withdrawing and modifying clinical privileges;\textsuperscript{214}

9.4.1.3.2. A procedure for applying these criteria to individuals requesting privileges.\textsuperscript{215}

9.4.1.4. Ensure that patients receive appropriate and medically necessary care from a Member of the Medical Staff during the entire length of stay with the Hospital;\textsuperscript{216}

9.4.1.5. Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Department/Section, across Department/Sections, and between members and non-members of the Medical Staff with clinical privileges;\textsuperscript{217}

9.4.1.5.1. By establishing uniform patient care processes;\textsuperscript{218}

9.4.1.5.2. By establishing similar clinical privileging criteria for similar privileges;\textsuperscript{219}

9.4.1.5.3. By using similar indicators in performance improvement activities.\textsuperscript{220}

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

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

9.4.2. ADMINISTRATIVE FUNCTIONS

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

9.4.2.2. Ensure that individuals within the Department/Section who admit patients have privileges to do so,\textsuperscript{221} and that all individuals within the Department/Section with clinical privileges only provide services within the scope of privileges granted.\textsuperscript{222}

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

\textsuperscript{214}42 C.F.R. §482.22(c)(6), CMS Survey Procedures
\textsuperscript{215}42 C.F.R. §482.22(c)(6), CMS Survey Procedures
\textsuperscript{216}MS.03.01.01
\textsuperscript{217}MS.01.01.01; LD.01.05.01
\textsuperscript{218}MS.08.01.03
\textsuperscript{219}MS.01.01.01; LD.01.05.01
\textsuperscript{220}MS.01.01.01; LD.01.05.01
\textsuperscript{221}MS.03.01.01, MS.06.01.07
\textsuperscript{222}MS.08.01.03
9.4.2.4. Provide recommendations to the Department/Section Chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Department/Section members.

9.4.3. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY ACTIVITIES

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

9.4.3.2. Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals.\(^{223}\)

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

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

9.4.4. COLLEGIAL AND EDUCATIONAL FUNCTIONS

9.4.4.1. Recommend medical educational programs to meet the needs of Department/Section members, based on the scope of services provided by the Department/Section, changes in medical practice or technology, and the results of Department/Sectional performance improvement activities.\(^{224}\)

9.5. FUNCTIONS OF DIVISIONS

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

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

9.5.2. The Division may be requested by the Department/Section Chairperson or Medical Executive Committee to meet to discuss specific issues related to quality assessment, peer review, performance improvement, and/or credentialing. In such cases, the Division shall report their findings directly to the Department/Section Chairperson or the Medical Executive Committee.

9.6. OFFICERS OF DEPARTMENT/SECTIONS AND DIVISIONS

9.6.1. IDENTIFICATION

The officers of the Department/Sections and Divisions shall be the

\(^{223}\) MS.03.01.01; 42 C.F.R. §482.22

\(^{224}\) MS.12.01.01
Department/Section Chairperson, the Department/Section Vice-Chairperson, and the Division Director.

9.6.2. QUALIFICATIONS

The officers of the Department/Sections and Divisions shall be active staff members in good standing. Each Department/Section Chairperson and Vice-Chairperson shall have demonstrated ability in at least one of the clinical areas of the Department/Section. The Division Director shall have demonstrated ability in the specialty represented by the Division. All officers of the Department/Sections and Divisions shall be certified by an appropriate specialty board, or affirmatively establishes comparable competence through the credentialing process.

9.6.2.1. Each Department/Section Chairmen shall:

9.6.2.1.1. Be an Active Staff member;
9.6.2.1.2. Be certified by an appropriate specialty board or equivalent, as determined through the credentialing and privileging process; and
9.6.2.1.3. Satisfy the eligibility criteria set forth for Medical Staff Officers.

9.6.3. ATTAINMENT OF OFFICE

Department/Section officers shall be elected by a majority vote of the Department/Section members eligible to vote of each even numbered year. The officers selected during the election shall be subject to ratification by the Board and shall take office at the beginning of the subsequent medical staff year. The Chairperson of the Department/Section to which the Division is affiliated shall appoint the Division Director.

9.6.4. TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

Department/Section officers shall serve a term of office of two years.

9.6.5. RESIGNATION

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

9.6.6. REMOVAL

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

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225 MS.01.01.01, MS.06.01.07, LD.04.01.05
226 MS.01.01.01
227 MS.01.01.01
228 MS.01.01.01
9.6.6.1. Failure to perform the duties of office;

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

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

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

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

At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board of Trustees prior to a vote on removal.

9.6.7. RECALL

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

9.6.8. VACANCY

In the event of a vacancy in one of the Department/Section officer positions, the Medical Staff President shall appoint an interim officer until an election can be held at the next Department/Section meeting.

9.6.9. RESPONSIBILITY AND AUTHORITY

9.6.9.1. Department/Section Chairperson: Each Department/Section Chairperson shall be responsible for the organization of the Department/Section and delegation of duties to Department/Section members to promote quality of patient care in the Department/Section. Members of the Department/Section and others with clinical privileges in the Department/Section shall be responsible to the Department/Section Chairperson. Each Department/Section Chairperson shall be responsible for the following duties:

9.6.9.1.1. Presiding at all meetings of the Department/Section;
9.6.9.1.2. Appointing Department/Section members to the positions of Division Director and to membership positions on Department/Sectional committees, if any;

9.6.9.1.3. Serving as an ex-officio Member of all Department/Sectional committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;

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

9.6.9.1.5. Conducting all clinically related activities of the Department/Section;\(^{230}\)

9.6.9.1.6. Conducting all administratively related activities of the Department/Section, unless otherwise provided by the Hospital;\(^{231}\)

9.6.9.1.7. Continuing surveillance of the professional performance of all individuals in the Department/Section who have delineated clinical privileges;\(^{232}\)

9.6.9.1.8. Participating in the evaluation of Practitioners practicing within the Department/Section;\(^{233}\)

9.6.9.1.9. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department/Section;\(^{234}\)

9.6.9.1.10. Recommending clinical privileges for each Member of the Department/Section;\(^{235}\)

9.6.9.1.11. Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department/Section or the Hospital;\(^{236}\)

9.6.9.1.12. Integrating the Department/Section into the primary functions of the Hospital;\(^{237}\)

9.6.9.1.13. Coordinating and integrating interDepartment/Sectional and

\(^{230}\) MS.01.01.01, MS.06.01.07, LD.04.01.05
\(^{231}\) MS.01.01.01, MS.06.01.07, LD.04.01.05
\(^{232}\) MS.01.01.01, MS.06.01.07, LD.04.01.05
\(^{233}\) MS.01.01.01, MS.06.01.07, LD.04.01.05
\(^{234}\) MS.01.01.01, MS.02.01.01, MS.06.01.07, LD.04.01.05, 42 C.F.R. §482.22(c)(6)
\(^{235}\) MS.01.01.01, MS.06.01.07, LD.04.01.05
\(^{236}\) MS.01.01.01, LD.04.03.01, LD.04.03.09
\(^{237}\) MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

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9.6.9.1.14. Developing and implementing policies and procedures that guide and support the provision of services;

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

9.6.9.1.16. Determining the qualifications and competence of Department/Section personnel who are not licensed independent practitioners and who provide patient care services;

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

9.6.9.1.18. Maintaining quality control programs, as appropriate;

9.6.9.1.19. Ensuring the orientation and continuing education of all persons in the Department/Section;

9.6.9.1.20. Recommending appropriate space and other resources needed by the Department/Section.

9.6.9.2. Department/Section Vice-Chairperson: The Vice-Chairperson shall assist the Department/Section Chairperson in the performance of the Chairperson’s duties, and shall assume the duties of the Chairperson in his/her absence.

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

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

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

10. FUNCTIONS AND COMMITTEES

10.1. FUNCTIONS OF THE STAFF

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

10.1.1. GOVERNANCE

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

10.1.1.1. Establish a framework for self-governance of Medical Staff activities and accountability to the Board.246

10.1.1.2. Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.247

10.1.2. PLANNING

The leaders of the Hospital include members of the Board, the Chief Executive Officer and other senior managers, Department/Section leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Department/Sections and other Medical Staff members in medico-administrative positions, and the Chief Nursing Officer and other senior nursing leaders.248 Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

10.1.2.1. Planning patient care services;249

10.1.2.2. Planning and prioritizing performance improvement activities;250

10.1.2.3. Budgeting;251

10.1.2.4. Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Department/Sections, across Department/Sections, and between members and non-members of the Medical Staff who have delineated clinical privileges;252

10.1.2.5. Recruitment, retention, development, and continuing education of all staff;253

246 MS.01.01.01, MS.01.01.03
247 MS.03.01.03, LD.1.10, LD.03.04.01
248 Joint Commission Comprehensive Accreditation Manual for Hospitals, Glossary
249 LD.02.01.01
250 LD.03.03.01; LD.03.05.01; LD.04.04.01; PI.03.01.01
251 LD.04.01.03
252 LD.02.01.01; MS.01.01.01; LD.01.05.01
253 LD.02.01.01, LD.03.06.01
10.1.2.6. Consideration and implementation of clinical practice guidelines as appropriate to the patient population.\textsuperscript{254}

10.1.2.7. Establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or Department/Section.\textsuperscript{255}

10.1.2.8. When emergency services are provided at the Hospital but not at one or more off-campus locations of the Hospital, the Medical Staff shall have policy and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.\textsuperscript{256}

10.1.2.9. If emergency services are not provided at the Hospital, the Medical Staff shall have written policy and procedures for appraisal of emergencies, initial treatment, and referral of patients when needed.\textsuperscript{257}

10.1.2.10. The Medical Staff shall attempt to secure autopsies in all cases of unusual deaths and of medical legal and educational interest.\textsuperscript{258}

10.1.2.11. The Medical Staff, specifically the attending physician, shall be informed of autopsies that the Hospital intends to perform.\textsuperscript{259}

10.1.2.12. To participate in, and monitor the Medical Center’s medical education and training programs.

10.1.2.13. To develop bylaws and rules and regulations that are consistent with sound professional practices and organizational principles, and to enforce compliance with them.

10.1.2.14. To participate in the Medical Center’s long-range planning activity, to assist in identifying community health needs and to work jointly with the Board of Trustees in developing and implementing appropriate institutional policies and programs to meet those needs.

10.1.3. CREDENTIALING

The Medical Staff is fully responsible to the Board for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of clinical privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

10.1.3.1. Establish specifically defined mechanisms for the process of
10.1.3.2. Establish professional criteria for membership and for clinical privileges. 260

10.1.3.3. Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges. 262

10.1.3.4. Submit recommendations to the Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges. 263

10.1.3.5. Establish a mechanism for fair hearing and appellate review. 264

10.1.3.6. Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted. 265

10.1.4. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Board requires that the Medical Staff is accountable to the Board for the quality of care provided to patients. 266 All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital’s quality assessment and performance improvement activities. 267 All organized services related to patient care shall be evaluated. 268 The Hospital’s quality assessment and performance improvement activities shall be described in detail in the Performance Improvement Plan. Through the activities of the Medical Staff Department/Sections and Divisions, the Medical Staff Quality/Peer Review Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below. 269 The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members and the Board of Trustees. 270

10.1.4.1. The Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program. The Board, the Medical Staff, and Administration shall be responsible and

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260 MS.01.01.01
261 MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03
262 MS.06.01.07
263 MS.01.01.01, MS.06.01.03, MS.06.01.07
264 MS.10.01.01
265 MS.08.01.03
266 42 C.F.R. §482.12(a)(5)
267 MS.01.01.01, MS.05.01.01, MS.06.01.07, MS.08.01.03; 42 C.F.R. §482.22(a)(1)
268 42 C.F.R. §482.21(a)(1)
269 42 C.F.R §482.22(a)(1), 42 C.F.R. §482.22(c)(3), Survey Procedures
270 MS.05.01.03
accountable for ensuring the following:

10.1.4.1.1. That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

10.1.4.1.2. That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.

10.1.4.1.3. That clear expectations for safety are established.

10.1.4.1.4. That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital’s performance and reducing risk to patients.

10.1.4.1.5. That the determination of the number of distinct improvement projects is conducted annually.

10.1.4.2. **Medical Staff Leadership Role in Performance Improvement**: The Medical Staff shall perform a leadership role in the Hospital’s quality assessment, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges. Such activities shall include, but are not limited to a review of the following:

10.1.4.2.1. Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;

10.1.4.2.2. Root cause analysis, investigation and response to any unanticipated adverse events;

10.1.4.2.3. Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;

10.1.4.2.4. Review and analysis of performance based on the results of core measures and other publicly reported performance information;

10.1.4.2.5. Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;
10.1.4.2.6. Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;278

10.1.4.2.7. Use of blood and blood components, including the review of any significant transfusions reactions;279

10.1.4.2.8. Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;280

10.1.4.2.9. Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;281

10.1.4.2.10. Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff; and,282

10.1.4.2.11. Use of developed criteria for autopsies.283

10.1.4.3. Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes.284 Such activities shall include, but are not limited to a review of the following:

10.1.4.3.1. Analyzing and improving patient satisfaction;285

10.1.4.3.2. Education of patients and families;286

10.1.4.3.3. Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and,287

10.1.4.3.4. Accurate, timely, and legible completion of patients’ medical records, including a review of medical record delinquency rates;288
10.1.4.3.5. The quality of history and physical exams; 289
10.1.4.3.6. Surveillance of nosocomial infections. 290

10.1.4.4. **Medical Staff Peer Review:** Findings relevant to an individual are used in an ongoing evaluation of the individual’s competence. 291 When the findings of quality assessment or performance improvement activities are relevant to an individual’s performance and the individual is a Medical Staff Member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in peer review or the ongoing evaluations of the individual’s competence. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately. 292

10.1.5. **CONTINUING AND GRADUATE MEDICAL EDUCATION**

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education. 293 In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital’s mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Hospital policy. 294 The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

10.1.5.1. The type and nature of care offered by the hospital; and, 295

10.1.5.2. The findings of performance improvement activities. 296

Additionally, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of house staff members in carrying out their patient care responsibilities. 297

Competency and peer review shall be a joint effort between the sponsoring organization, the CME program director, the MEC and BOT.

10.1.6. **BYLAWS REVIEW AND REVISION**

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

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289 MS.03.01.01
290 IC.01.03.01; 42 C.F.R. §482.21(a)(2); 42 C.F.R. §482.42(b)(1–2)
291 MS.05.01.03
292 MS.05.01.03; 42 C.F.R. §482.22(a)(1)
293 MS.12.01.01
294 MS.12.01.01, HCA, Ethics & Compliance Policy LL.010
295 MS.12.01.01
296 MS.12.01.01
297 MS.04.01.01
125
10.1.6.1. Remain consistent with the Bylaws of the Board of Trustees;

10.1.6.2. Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;

10.1.6.3. Remain current with the Medical Staff’s organization, structure, functions, responsibilities and accountabilities; and,

10.1.6.4. Remain consistent with Hospital policies.

10.1.7 MEDICAL STAFF ACTION

The affirmative vote on any matter of a majority of the Active Staff members in good standing present at a regular or special Staff meeting at which a quorum is present, provided that a copy of the proposed documents or amendments was given or made available to each Staff member entitled to vote thereon with or at the time of notice of the meeting shall constitute its action. The Medical Staff’s affirmative action shall be forwarded to the Board of Trustees for its action. Other Staff action shall be transmitted to the Board of Trustees for their information.

Amendments to these bylaws may also be voted upon by polling the medical staff either by mail, e-mail and/or fax. The majority of votes either affirmative or negative of those who respond will be the deciding vote. The action taken by this vote shall be transmitted to the Board of Trustees for its action.

10.1.8 BOARD OF TRUSTEES ACTION

10.1.8.1 WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION

Medical Staff recommendations are approved upon the affirmative vote of a majority of the Board of Trustees. The effective date of such approved recommendations shall be on the date approved or at such later date as the Board of Trustees may specify.

10.1.9 WHEN CONTRARY TO OR WITHOUT BENEFIT OF MEDICAL STAFF RECOMMENDATION

(a) Notice to Staff: Whenever the Board is contemplating either:

- taking action on Bylaws or amendments thereto which is contrary to the recommendation of the Medical Staff; or
- taking action on Bylaws or amendments thereto without having received a recommendation on the matter from the Medical Staff,

The Board of Trustees shall within Thirty (30) days of such discussion or contemplation, including any formal action, inform
the Staff in writing of its concerns, of the reasons therefore, and of the date by which the Staff's response is requested which shall be not less than five (5) nor more than thirty (30) days after the date of the notice.

(b) Action Following Staff Response: The Board of Trustees should communicate with the Medical Staff Executive Committee within (15) working days. Final action will be by the Board of Trustees.

10.1.7. MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING

The Medical Staff shall provide a mechanism for developing future medical staff leaders by defining desired leadership characteristics, identifying and recruiting future potential medical staff leaders from among the Members of the Medical Staff, and determining the education and development needs of potential medical staff leaders so as to be successful in future roles. The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization.

10.2. PRINCIPLES GOVERNING COMMITTEES

The key functions of the Medical Staff shall be performed ongoing through the activities of the Department/Sections, Divisions, and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees. The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the standing committees, the Medical Executive Committee or the Medical Staff President may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

10.3. DESIGNATION

The current standing committees of the Medical Staff are the Medical Executive; Credentials; Health Information, Graduate Medical Education, Nominating, Administrative Affairs, Utilization Management, Clinical Risk, Infection Prevention, Pharmacy & Therapeutics, and Transfusion. Standing committees responsible to the Internal Medicine Executive Committee is the Endoscopy Committee.

10.4. OPERATIONAL MATTERS RELATING TO COMMITTEES

10.4.1. REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may
collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation. Medical Staff representatives for a Hospital committee shall be appointed by the Medical Staff President with input from the Chief Executive Officer or Chief Medical Officer

10.4.2. EX OFFICIO MEMBERS

The Chief Executive Officer and Chief Medical Officer shall be ex-officio members of all Medical Staff committees. The Chief Executive Officer may designate another senior administrative Member to attend any meeting in his/her place. At the prerogative of the Board of Trustees, Board Member(s) may be appointed by the Board of Trustees to serve as representative(s) of the Board of Trustees on any Medical Staff committee or Hospital committee. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

10.4.3. APPOINTMENT OF CHAIRPERSON AND MEMBERS

The Medical Executive Committee shall appoint Medical Staff members to Medical Staff standing committee positions. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, and any other committee performing a professional review activity shall be subject to ratification by the Board per Article Eight, Section 8.3.3 of these Bylaws. The Chief Executive Officer, in consultation and with the approval of the Medical Staff President, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

10.4.4. TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee Member shall be two (2) years.

If a chairperson or Member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the Medical Staff President, the Medical Executive Committee, or the Board may remove that Member from the committee position. As a condition of serving on a committee, and by virtue of having accepted the appointment, each Member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the Member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.
10.4.5. NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally or electronically

10.4.6. MEETINGS

The frequency of meeting shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee. All business meetings for all committees, subcommittees, Department/Sections, and Divisions shall be held on the campus of the Hospital. Meetings may also be held through secure teleconference or secure web-based technology provided that off-site participants are able to view all of the documentation being presented, are able to interactively participate in the discussion, and are able to cast their vote either verbally, or through an approved alternative, i.e., web-supported voting system, fax, or email as approved by the Hospital.

10.4.7. QUORUM

(a) General and Special Staff Meetings – Those members of the Active Staff in good standing who are present at any regular or special meeting constitute a quorum for the transaction of any business under the Bylaws and any related Manual,

(b) Clinical Service, Departments, committees or any other clinical unit meetings - Fifteen percent (15%) of the qualified voting members in good standing of the service, etc., but not fewer than three (3) members, constitutes a quorum for the transaction of any business under the Bylaws and any related Manual.

10.4.8. MANNER OF ACTING

Once a quorum has been established, a committee shall take action with a majority of the votes by those who are present and who have voting rights. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote.

10.4.9. ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee’s written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee.

10.4.10. MINUTES

Each committee and subcommittee shall record minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee’s or subcommittee’s conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other
materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years, \(^{305}\) after which they may be placed in archive storage, for perpetuity.

10.4.11. PROCEDURES

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

10.4.12. REPORTS

Each standing and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part.

10.4.13. COMMITTEES, DEPARTMENT/SECTIONS AND DIVISIONS WITH PEER REVIEW RESPONSIBILITIES

Peer review is the concurrent or retrospective review of an individual’s professional qualifications, professional competence, or professional conduct, including through clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, except as may otherwise be provided in the Medical Center’s statutorily required risk Management Plan

10.4.13.1 Purpose of Peer Review: The purpose of the Hospital’s peer review processes, programs, and proceedings is to encourage candid discussions in a private and confidential setting among Practitioners, other individuals with clinical privileges and other health care personnel to accomplish the following objectives:

10.4.13.1.1. To improve the quality of health care provided to patients;

10.4.13.1.2. To reduce morbidity and mortality at the Hospital;

10.4.13.1.3. To improve the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Practitioners, other individuals with clinical privileges, and other health care professionals who provide care to patients at the Hospital; and,

10.4.13.1.4. To maintain confidentiality of information generated during the course of peer review processes, programs and proceedings.

10.4.13.2. Peer Review Information: All peer review information shall be kept private and confidential. A Practitioner, other individual with clinical privileges, or other Hospital staff Member who participates or has participated in a peer review process at the Hospital shall treat all peer review information as private, confidential and privileged and shall not disclose peer review information obtained, generated or compiled

\(^{305}\) HCA, Ethics & Compliance Policy EC.014, Record Series Code ADM-90-09

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during a peer review process in which he/she participates unless specifically and expressly authorized by the Hospital to do so or as required by law.

10.4.13.3. **Hospital Committees or Functions:** A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: patient safety, performance improvement, utilization management, credentialing, infection control, review of use of operative and invasive procedures, review of medical records, review of use of medications, review of use of blood and blood components, clinical risk management, quality assessment, any other review or investigation of professional performance or conduct, and fair hearings and appeals conducted pursuant to the Medical Staff Fair Hearing Plan.

10.4.13.4. **Circumstances for Peer Review:** The primary purpose of peer review activities shall be to improve an individual’s performance. Peer review analysis shall be conducted whenever data comparisons indicate that the level of an individual’s performance patterns or trends vary substantially from the expected. Peer review shall also be conducted for unanticipated adverse events when root cause analysis indicates human factors related to an individual’s performance are possibly significant to the cause of the event. Peer review may be conducted for other reasons including, but not limited to, situations involving an individual case that may fall outside the standard of care, or failure to comply with Hospital policies and procedures, or in any other circumstance deemed necessary by the Medical Staff President, Chief Executive Officer/CMO, Medical Executive Committee, or any other committee authorized to review or evaluate an individual’s performance, or the Board of Trustees. An external reviewer or review panel may be used when the Medical Staff lacks necessary expertise, or when there is a question of conflict of interest, or when additional review is needed to confirm peer review results, or in any other circumstance in which external review is deemed necessary by the Medical Staff President, Chief Executive Officer/CMO, Medical Executive Committee, or any other committee authorized to review or evaluate an individual’s performance, or the Board of Trustees.

10.4.13.5. **Peer Review Panel:** Professional review shall be conducted by a professional review body (e.g., a committee with a designated peer review function or an ad hoc peer review panel), any person acting as a Member or staff to a professional review body, or any person under contract with a professional review body. Ad hoc peer review panels may be selected for specific focused review by the Medical Staff President, Chief Executive Officer/CMO, Medical Executive Committee, any other Medical Staff committee authorized to review

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306 PI.02.01.01
307 PI.02.01.01
308 MS.08.01.01; MS.08.01.03; MS.09.01.01
309 HCQIA, §11111(a)(1)(A-C)

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10.4.13.6. **Timeframes for Review:** Focused peer review activities shall be conducted and the results reports within a timeframe as established by policy or outlined in the bylaws. In circumstances requiring ongoing review before a determination can be made, an interim report may be submitted within the defined timeframe if the final report will not be completed within the defined timeframe.

10.4.13.7. **Participation in Review:** The individual whose performance or conduct is being reviewed shall have an opportunity to participate in the peer review process, either through attendance at a meeting in which the peer review results are discussed, in interviews with peer reviewers, or any other form of communication or correspondence with peer reviewers or the peer review panel. If the individual has been offered an opportunity to participate but the individual decides not to participate, the review may be concluded and final results reported without the participation of the individual.

10.4.13.8. **Records and Minutes:** The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. Peer review records and information will be identified with a conspicuous notation or stamp, for example: CONFIDENTIAL PEER REVIEW INFORMATION. The names (or QA numbers) of individuals who present or provide information during a peer review process should be documented.

10.4.13.9. **Custody:** Peer review information, including Medical Staff records, shall be maintained under the custody of the Medical Staff President and the Chief Executive Officer/Chief Medical Officer or designee.

10.4.13.9.1. A Practitioner or other individual with clinical privileges shall be permitted access to further information in his or her own credentials and peer review file only if, following a written request by the individual, the Chief Executive Officer/Chief Medical Officer, in consultation with the Medical Staff President and legal counsel, finds that the individual has a compelling need for such information and grants written permission. A Practitioner or other individual with clinical privileges shall be permitted access to further information in that credentials file only if, following a written request by the individual, the Medical Executive Committee and the Board find that the individual has a compelling need for such information and grants written permission. Factors to be considered...
include the reasons for which access is requested; whether the release of information might have an adverse effect on the Hospital, the Medical Staff, the individual or other persons; whether the information could be obtained in a less intrusive manner; whether the information was provided to the Hospital in specific reliance upon continued confidentiality; whether a harmful precedent might be established by the release; and such other factors as might be considered appropriate. The Medical Executive Committee or the Board may enforce restrictions or conditions if access is permitted.

10.4.13.10. **Medical Staff Officers**: Members of the Board, licensing agencies, accreditation and regulatory authorities, the Chief Executive Officer, counsel to the Hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and official functions. The Board and the Chief Executive Officer/Chief Medical Officer and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions.

10.4.13.11. **Outside Requests for Information**: The Medical Staff Services and the Medical Staff President/Chief Medical Officer (or his designee) may release information contained in Medical Staff files in response to a proper request from another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. However, when the request seeks information considered to be privileged under the Kansas peer review and/or risk management statutes, the information shall not be disclosed without first contacting the Medical Center’s Risk Manager/CMO or legal counsel.

10.4.13.12. **Reporting Obligations**: If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state
professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes.

10.4.13.13. **Surveyor Review:** Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff Office records on the Hospital premises in the presence of Medical Staff Hospital personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or other legal requirements, (b) access is provided only with the concurrence of the Chief Executive Officer /Chief Medical Officer(or his/her designee) and the Medical Staff President (or his/her designee), and (c) the surveyor demonstrates the following to the satisfaction of the Chief Executive Officer/Chief Medical Officer or Medical Staff President:

10.4.13.13.1. **Specific statutory, regulatory or other appropriate authority to review the requested materials;**

10.4.13.13.2. **The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;**

10.4.13.13.3. **The materials sought are the most direct and least intrusive means to accomplish the purpose;**

10.4.13.13.4. **Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital;**

10.4.13.13.5. **If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.**

10.4.13.14. **Subpoenas:** All subpoenas of Medical Staff records shall be referred to the Chief Executive Officer/Chief Medical Officer and the Medical Staff President.

10.4.13.15. **Legal Counsel:** Legal counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.

10.4.13.16. **Other Requests:** All other requests by persons or organizations for information contained in Medical Staff
records shall be forwarded to the Chief Executive Officer/Chief Medical Officer and the Medical Staff President for evaluation.

10.4.13.17. Peer Review Meetings: All peer review functions shall be performed only at meetings held on the campus of the Hospital.

10.5. MEDICAL EXECUTIVE COMMITTEE

10.5.1. COMPOSITION

All members of the medical staff from any discipline or specialty, who are in good standing and have participated for a minimum of two (2) years, are eligible to serve on the Medical Executive Committee, if currently serving on a section executive committee. This usually is the Chairperson of the Service, or the Medical Director of Pathology, Radiology or Emergency Department.

The Medical Executive Committee consists of:

- President of the Medical Staff, as Chairperson and with vote;
- Vice President (President Elect)
- Secretary-Treasurer
- Immediate Past President
- Chairperson of the following services: Anesthesiology, Cardiology, Family Medicine, Internal Medicine, Surgery, Obstetrics-Gynecology, Orthopedics and Pediatrics
- Medical Directors from each of the Hospital Departments of Pathology, Radiology and Emergency Medicine
- Two (2) representatives from the Galichia Campus Medical Leadership Collaborative, with vote.
- Chief Executive Officer and/or designee, without vote

10.5.2. DUTIES AND AUTHORITY

The responsibilities and authority of the Medical Executive Committee are to:

- Act for the Medical Staff, subject to such limitations as are imposed in these Bylaws or by the Staff. When the Committee takes immediate action on an emergency matter that should normally be acted on by the Staff, it reports such action at the next regular Staff meeting, giving full details showing logical cause for its decision to assume responsibility.
- Consider all questions which are to come before the regular Staff meetings and make recommendations to the Staff concerning them
- Receive, coordinate and act upon the written reports and recommendations of the Services and Departments and the standing or special committees directly responsible to them and to hear oral reports from time to time as required.
- Implement the approved policies of the Medical Staff.
- Study and report to the Medical Staff on proposals for changes in the Bylaws, Rules and Regulations.
- Inform the Medical Staff and Housestaff about The Joint Commission
accreditation programs and the accreditation status of the Hospital.

- Approve the appointment of Chairperson and members of standing committees (except as otherwise provided).
- Recommend to the Board of Trustees concerning all matters relating to appointments and reappointments, staff categorization, department/service assignments, clinical privileges, and disciplinary action.
- Account to the Board of Trustees by written report for the quality and efficiency of medical care rendered to the patients in the Hospital.
- Determine and enforce disciplinary action in accordance with these bylaws and policy and make recommendations to the Board of Trustees accordingly.
- Make recommendations to the Medical Education Council.
- Recommend to the Board of Trustees for its approval:
  - The structure of the Medical Staff;
  - The mechanism used to review credentials and to delineate individual clinical privileges;
  - The organization of the Medical Staff’s performance improvement activities and the mechanism used to conduct, evaluate and revise such activities;
  - The mechanism by which membership on the Medical Staff may be terminated; and
  - The mechanism for fair hearing procedures.

10.5.3. MEETINGS AND REPORTING
The Medical Executive Committee meets at least monthly. It communicates its discussions and actions by minutes available in the Medical Staff Office.

10.6. CREDENTIALS COMMITTEE

10.6.1. COMPOSITION
The Credentials Committee shall include:

- Chairperson of Surgery, Internal Medicine, Ob/Gyn, Family Medicine, Pediatrics and Anesthesia;
- Immediate Past President of the Medical Staff
- Representative from Administration responsible for credentialing system support, without vote
- Medical Staff Office representative, without vote

The Medical Executive Committee may appoint up to three (3) additional members from the Active Medical Staff, upon the recommendation of the Credentials Committee

10.6.2. DUTIES AND AUTHORITY
The Credentials Committee shall coordinate the Medical Staff credentials function by receiving applications and recommendations for appointment, provisional period conclusion or extension, reappointment, clinical privileges, and changes therein, and recommending action thereon, and by integrating
performance improvement monitoring, membership and other relevant information into individual credentials files. It also shall assist in designing and overseeing implementation of the credentialing procedures for allied health professionals functioning under a Medical Staff member’s supervision and control. It shall meet monthly and report to the Medical Executive Committee regarding the credentialing of staff members and of those categories of allied health professionals who are under the direction and control of the various Staff members and/or who are employed by Staff members.

- Review, evaluate and transmit written reports as required by the Medical Staff bylaws and Credentialing Procedures Manual on the qualifications of each applicant or member for appointment, concluding or extending the provisional period, reappointment, or modification or appointment and for clinical privileges, and of each Allied Health Professional for the performance of specified services;
- Initiate, investigate, review and report on corrective action matters and on any other matters involving the clinical, ethical or professional conduct of any practitioner assigned or referred by:
  - The President of the Medical Staff
  - The Medical Executive Committee
  - The Board of Trustees
- Submit written reports as requested or required to the Medical Executive Committee on the status of pending applications or other credentials matters, including the specific reasons for an inordinate delay in their processing;
- Maintain a credentials file for each member of the Medical Staff

10.6.2.1. Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Department/Sections, across Department/Sections, and between members and non-members of the Medical Staff who have delineated clinical privileges;\footnote{LD.3.20; MS.01.01.01; LD.01.05.01}

10.6.3. MEETINGS AND REPORTING

The Credentials Committee shall meet at least monthly, and shall report their recommendations and activities to the Medical Executive Committee.\footnote{MS.02.01.01}

10.7. PRACTITIONER HEALTH COMMITTEE

10.7.1. COMPOSITION

The Practitioner Health Committee shall be composed of Lay persons, including one lay board member, CMO, CEO/COO, Risk Coordinator, Past President of the Medical Staff, RN of Director Level).

10.7.2 DUTIES
The Practitioner Health Committee shall perform the key functions of the Practitioner Health program as outlined in these bylaws; in the Section related to Practitioner Health Issues. The Practitioner Health Committee shall:

10.7.2.1 Recommend education for all Medical Staff and Hospital staff regarding practitioner health issues, including how to identify and report potential issues;

10.7.2.2 Develop and recommend policies for the Practitioner Health Program, such policies to include self referral, referral by others, evaluating credibility of a reported concern, resources for evaluation, diagnosis and treatment, maintaining confidentiality, monitoring practitioners under rehabilitation, intervening when patient safety is at risk, and taking appropriate actions;

10.7.2.3 Evaluate self-referrals and third party reports regarding potential practitioner health issues;

10.7.2.4 Conduct investigations of potential practitioner health issues;

10.7.2.5 Make recommendations for treatment and rehabilitation regarding practitioner health issues;

10.7.2.6 Monitor individuals under treatment and rehabilitation for practitioner health issues;

10.7.2.7 Make recommendations for reinstatement of clinical privileges following an individual’s treatment and rehabilitation for practitioner health issues.

10.7.3 MEETINGS AND REPORTING

The Practitioner Health Committee shall meet as needed to review the Practitioner Health program and policies, and shall determine the frequency of other meetings based on frequency of activities related to reporting and monitoring practitioner health issues.

10.8. ADVANCED PRACTICE PROFESSIONALS REVIEW COMMITTEE

10.8.1. COMPOSITION

The Advanced Practice Professionals Review Committee shall be appointed by the Chief Executive Officer. Permanent members of the committee shall include the Chief Medical Officer, the Chief Nursing Officer, the Medical Staff President or a designee, and the Medical Staff Services Director. Rotating members of the committee, depending on the type of APP being considered, shall be the relevant medical staff Department/Section chief(s) or designee(s), hospital Department/Section head(s) or nurse manager(s) of the Department/Sections in which the APP would work.

10.8.2. DUTIES

The Advanced Practice Professionals Review Committee shall:

10.8.2.1. Evaluate and make recommendations to the Board regarding the need for the services that could be provided by types of APPs that are not
currently permitted to practice in the hospital;

10.8.2.2. Develop and recommend policies for each type of APPs permitted by the Board to practice in the hospital. Such policies shall specify training, education and experience requirements for applicants, the scope of practice or clinical privileges to be granted, any conditions that apply to the APPs’ functioning within the hospital, any ongoing supervision requirements, and malpractice insurance requirements;

10.8.2.3. The Credentials Committee will review the qualifications of all APPs who apply for permission to practice in the hospital, interview such applicants as may be necessary, and make a written report of its findings and recommendations;

10.8.2.4. The Section/Department will review on an ongoing basis the quality of care provided by APPs at the hospital, including developing plans for focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) related to the professional practice of APPs and reviewing the data and making recommendations regarding continuation, limitation, or revocation of clinical privileges of each APP based on such data; and,

10.8.2.5. The Peer Review Committee, as questions arise, will review all information available regarding the clinical competence and/or professional conduct of APPs currently permitted to practice in the hospital and, as a result of such review, makes a written report of its findings and recommendations. APP peer may be requested to attend meeting.

10.8.3. MEETINGS AND REPORTING

The Advanced Practice Professionals Review Committee shall meet as often as necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall make a report of its recommendations after each meeting to the Board, through the Chief Executive Officer. The chairperson of the committee shall be available to meet with the Board, its committee or the Chief Executive Officer on all recommendations that the Advanced Practice Professionals Review Committee may make.

10.9. QUALITY FORUM

10.9.1. COMPOSITION

The Quality Forum is a multi-disciplinary committee to review hospital data, regulatory requirements and performance improvement programs to help coordinate activities at the medical center that will provide safety and quality for patients.

The Quality Forum shall include:
- Representatives from the Medical Staff;
- Representatives from the Hospital Staff; and
- Representatives from the Board of Trustees.
10.9.2. DUTIES AND AUTHORITY

Review, monitor and modify the specific programs and procedures for assessing and improving the quality and efficiency of medical care provided in the Medical Center;

May make specific recommendations to correct identified system problems;

Follow-up on action taken;

Monitor and review the Staff’s performance improvement activities with those of other healthcare disciplines thru the hospital quality and patient safety committee;

Annually evaluate the overall performance improvement program for its comprehensiveness, integration, effectiveness and cost efficiency.

10.9.3. MEETINGS AND REPORTING

The Quality Forum shall meet at least quarterly, and shall report their recommendations and activities to the appropriate section/department and Medical Executive Committee.\[316\]

10.10. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

The citywide GMEC (a/k/a Wichita Center for Graduate Medical Education Residency Committee) shall monitor and advise the Medical Executive Committee and the Board of Trustees on all aspects of residency/fellowship education conducted within Wesley Medical Center.

10.10.1. COMPOSITION

The GMEC shall include:

a) The KUSM-W Dean, Chairs, and Program Directors of all residency programs,

b) The hospital Administrative Director of Medical Education

c) The Chief Operative Officer of the Wichita Center for Graduate Medical Education

d) The UKSM-W Associate Dean for Graduate Medical Education

10.10.2. DUTIES

a) Review and approve residency/fellowship policies that affect clinical activities within Wesley Medical Center and/or the residents’ work environment within the Medical Center.

b) Review all ACGME letters of accreditation and the monitoring of action plans for correction of areas of non-compliance which impact patient care within Wesley Medical Center.

c) Review the process for all residency/fellowship programs to provide appropriate levels of supervision of residents within the Medical Center environment.
d) Review the process for all residency/fellowship programs to monitor and
delineate clinical competencies of residents relating to the
resident’s/fellow’s need for direct or indirect supervision.

e) Identify additional resources which may be required for the conduct of
graduate medical education within the Wesley environment.

10.10.3. MEETINGS AND REPORTING
The GMEC shall meet every other month and report to the Medical Executive
Committee.

10.11. ADMINISTRATIVE AFFAIRS COMMITTEE

10.11.1. COMPOSITION
The Administrative Affairs Committee shall include:

a) Immediate Past President of the Medical Staff, who will serve as chair.
b) A minimum of four (4) additional Active Staff members, appointed by
the President of the Medical Staff subject to Medical Executive
Committee approval;
c) Representative of Administration, without vote;
d) Individuals as appropriate by invitation;
e) Medical Staff Coordinator; without vote.

10.11.2. DUTIES AND AUTHORITY
The Administrative Affairs Committee shall fulfill Staff responsibilities
relating to revision of Medical Staff Bylaws and related manuals and forms,
and supervise overall Medical Staff compliance with accreditation and other
regulatory requirements applicable to the Medical Staff or any of its clinical
units.

The Administrative Affairs Committee shall coordinate, direct development of
or develop itself, and recommend to the Medical Executive Committee:

a) The clinical policies and rules of the Medical Staff and of its clinical units
and diagnostic and therapeutic support services (including OR/RR, ER,
ICU’s, CCU’s, etc.)

b) Conduct an ongoing review of the Bylaws, Rules and Regulations and
Procedure Manuals. These policy manuals should be reviewed/updated
at least every three (3) years.

c) Submit written recommendations to the Medical Executive Committee;
and/or the Medical Staff and to the Board of Trustees for changes in
these documents.

The Administrative Affairs Committee also shall coordinate with Nursing
and Administration for review and coordination of policies, procedures,
rules or regulations under joint Medical Staff-Administration or Medical
Staff-Nursing purview, serve as a forum for identifying and discussing
problems in the delivery of patient care services and in the observance of
patient’s rights, and work with Administration in the development of
policies relating to bioethical issues.
10.11.3. MEETINGS AND REPORTING

The Administrative Affairs Committee shall meet as needed, and report to the Medical Executive Committee.

10.12. NOMINATING COMMITTEE

10.12.1. COMPOSITION

The Nominating Committee shall be comprised of:

a) Vice President (President-Elect) of the Medical Staff as Chairperson
b) Medical Staff Officers
c) Chief Medical Officer

10.12.2. DUTIES AND AUTHORITY

The Nominating Committee shall develop a slate of one or more qualified nominees for the election of the Secretary-Treasurer and for the filling of any vacancy occurring in any of those offices if required as outlined in these Bylaws.

The Nominating Committee shall

a) Identify nominees for election to general Staff offices or to other elected positions in the Medical Staff organizational structure;

b) In accomplishing (a), consult with members of the Medical Staff or of the appropriate constituent group and the Board of Trustees concerning the qualifications and acceptability of prospective nominees.

10.12.3. MEETINGS AND REPORTING

The Nominating Committee shall meet on call of its Chairperson or of the Medical Executive Committee.

10.13 UTILIZATION MANAGEMENT

10.13.1 PURPOSE AND MEETINGS

The Utilization Management Committee shall develop and oversee implementation and operation of the utilization review and management plan, make utilization decisions as required under the plan, analyze utilization profiles and evaluate the effectiveness of the Utilization Management program. Physician members of the committee shall act as the physician advisors required by the Utilization Management plan.

The Utilization Management Committee shall meet on an as-needed basis and report to the Medical Executive Committee as needed.

10.13.2 FUNCTIONS

(a) Develop a utilization review and management plan for approval by the Medical Staff Executive Committee, Medical Center Administration, and the Board of Trustees;

(b) Review and monitor that the Utilization Review and Management plan is in effect, and functioning effectively at all times;
Analyze utilization profiles on a periodic basis and prepare written evaluations of the Utilization Review and Management activities when appropriate, including a determination of their effectiveness in allocating resources;

Conduct studies, take actions, submit reports and make recommendations as required by the Utilization Review and Management plan.

10.13.3 COMPOSITION

The Utilization Management Committee shall include:

(a) Chairperson, appointed by the President of the Medical Staff subject to Medical Executive Committee approval;

(b) Twelve (12) additional Medical Staff members, appointed by the President of the Medical Staff subject to Medical Executive Committee approval and selected to provide broad representation from the Medical Staff;

(c) Representative from Administration, without vote;

(d) Representative from Nursing Service, without vote;

(e) Representative from Care Coordination Department, without vote;

(f) Representative from Health Information Management, without vote.

10.14 TRANSFUSION COMMITTEE

10.14.1 PURPOSE AND MEETINGS

The Transfusion Committee shall ensure the systematic review of the transfusion of blood and blood components.

The Transfusion Committee shall meet quarterly and report its findings and recommendations for follow up and/or action to the Medical Executive Committee.

10.14.2 FUNCTIONS

(a) Conduct and/or participate in the performance improvement efforts as related to the use of blood and blood components, including:

- Ordering;
- Appropriateness of use;
- Distribution, handling, and dispensing;
- Administration; and Monitoring the blood and blood components’ effects on patients.

(b) Review all suspected transfusion reactions.

10.14.3 COMPOSITION

The Transfusion Committee shall include:

(a) Chairperson appointed by the President of the Medical Staff subject to approval by Medical Staff Executive Committee;

(b) Additional members representing the Services of Anesthesiology, Family Medicine or Pediatrics, Internal Medicine, Obstetrics/Gynecology,
10.15 PHARMACY & THERAPEUTICS COMMITTEE

10.15.1 PURPOSE AND MEETINGS

The Pharmacy & Therapeutics Committee is an advisory group of the Medical Center and serves as the organizational line of communication or liaison between the Medical Staff and the Pharmacy Department. This Committee is an interdisciplinary group of physicians, pharmacists and various ancillary departments. It is also a policy recommending body to the Medical Staff and to the Administration of the hospital on all matters relating to the medication use process and diagnostic testing materials in patient care. The Committee meets monthly and reports to the Medical Executive Committee of the Medical Staff at least quarterly.

10.15.2 FUNCTIONS

(a) Shall be responsible for development or approval of policies and procedures relating to the selection, procurement, storage, distribution, use and administration of drugs and diagnostic testing materials;
(b) Shall be responsible for development and maintenance of a drug formulary;
(c) Shall define and review all significant untoward drug reactions;
(d) Shall evaluate protocols concerned with the use of investigational and experimental drugs;
(e) Drug utilization evaluations shall be performed by the Medical Staff as a criteria based, ongoing, planned and systematic process designed to continuously improve, the appropriate, safe, and effective use of drugs.

10.15.3 COMPOSITION

The Pharmacy & Therapeutics Committee shall include:
(a) Chairperson appointed by the President of the Medical Staff, subject to Medical Executive Committee approval;
(b) At least four representatives from the various Clinical Services appointed by the President of the Medical Staff on an annual basis;
(c) Director of Pharmacy, without vote;
(d) One representative from Nursing Service, without vote;
(e) The Chairperson of the Anti-biotic Subcommittee with vote;
(f) Representative from Nutrition Department.

10.16 INFECTION PREVENTION COMMITTEE

10.16.1 PURPOSE AND MEETINGS

The Infection Prevention Committee is responsible for surveillance, prevention
and control of infection function by coordinating processes to reduce the risks of endemic and epidemic hospital acquired infections in patients and health care workers. The Committee shall meet quarterly and on call as necessary. Authority is vested in the Infection Prevention Committee Chairperson or designee by the Medical Staff and Administration to institute any appropriate prevention and control measures when there is reasonable cause to protect any patient, health care worker, and/or visitor.

10.16.2 FUNCTIONS

(a) Maintain an infection prevention and control process based on sound epidemiologic principles and hospital acquired infection research;
(b) Maintain a continuous and ongoing surveillance system;
(c) Maintain a functioning process supported by policies and procedures that outline prevention and control mechanisms in all patient care, service areas and employee health services that are in compliance with CDC guidelines, OSHA and other appropriate regulations;
(d) Directs the surveillance, prevention, and control of infection function of the infection prevention practitioners;
(e) Findings and recommendations shall be reported at least quarterly to Medical Staff Executive Committee and Administration.

10.16.2 COMPOSITION

(a) Chairperson, appointed by the President of the Medical Staff, subject to the Medical Staff Executive Committee approval;
(b) At least four physicians from the various Clinical Services;
(c) Administration;
(d) Department of Nursing;
(e) Department of Education;
(f) Department of Pathology (Clinical Microbiologist);
(g) Employee Health Coordinator;
(h) Employee Health Medical Director;
(i) Infection Prevention Practitioners;
(j) Department of Pharmacy (Infectious Disease Specialist);
(k) Chairperson Antibiotic Subcommittee/Medical Director  Antibiotic Streamlining.

10.17 HEALTH INFORMATION COMMITTEE

10.17.1 PURPOSE AND MEETINGS

The Health Information Committee shall fulfill staff function relating to health information policies and practices. Each Clinical Service will be charged with the enforcement of these policies. It shall monitor and make recommendations relating to the adequacy, completeness, legibility, and timeliness of medical records. The Health Information Committee shall meet at least every other month, or as needed, and report to the Medical Staff Executive Committee.

10.17.2 FUNCTIONS
(a) Review and evaluate health information documentation to determine that it: properly describes the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken; and is sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Medical Center;

(b) Develop, review, enforce and maintain surveillance over enforcement of Medical Staff and Medical Center policies and rules relating to health information, including medical records documentation and completion, preparation, forms, formats, filing, indexing, storage, destruction and availability and recommend methods of enforcement thereof and changes therein;

(c) Provide liaison with Medical Center Administration, Nursing Service and Health Information Management professionals in the employ of the Medical Center on matters relating to health information practices;

(d) Submit written reports as requested or required on the progress and results of the activity.

10.17.3 COMPOSITION

The Health Information Committee shall include:

(a) Chairperson appointed by the President of the Medical Staff, subject to Medical Staff Executive Committee approval;

(b) At least 6 additional Active Staff members selected to be representative of the major clinical areas by the President of the Medical Staff;

(c) Representative of Nursing Service, without vote;

(d) Director of Health Information Management, without vote;

(e) Representative of Administration, without vote.

10.18 CLINICAL RISK COMMITTEE (PEER REVIEW COMMITTEE)

10.18.1 PURPOSE AND MEETINGS

The Clinical Risk Committee is responsible for the Medical Staff peer review process as an integrated and coordinated effort to ensure continuous performance improvement of patient care and to comply with the mandates required by the Kansas Risk Management Law.

The Committee will meet monthly, and will forward their report to the Medical Executive Committee, and Board of Trustees.

10.18.2 FUNCTIONS

(a) Participates in the identification, investigation, categorizing, and analyzing of occurrences that could result in patient injury and potential liability, utilizing clinical indicator screens;

(b) Refer cases to the appropriate Clinical Chairperson for review and/or action;
(c) Monitor patterns and trends and identify opportunities for improvement.
(d) Acts as Physician Support Committee by reviewing behavioral issues or trends at the request of the CMO

10.18.3 COMPOSITION
The Clinical Risk Committee shall include:
(a) Chairperson will be selected from the committee members.
(b) Minimum of ten (10) members representing clinical review areas for peer review process;
(b) Chief Medical Officer;
(c) Director Risk Management; without vote,
(d) Risk Management Coordinator, without vote;
(e) Legal counsel and other consultants as required, without vote;
(f) Nursing Representative on call as needed.

10.19 ENDOSCOPY COMMITTEE

10.19.1 PURPOSE AND MEETINGS
The Endoscopy Committee shall fulfill staff functions relating to the practice of endoscopy within the Medical Center. The Committee shall meet on an on-call basis and shall report to the Internal Medicine Executive Committee.

10.19.2 FUNCTION
(a) Design, measure, assess and improve the endoscopic procedures performed in the Medical Center;
(b) Participate in the Performance Improvement and Clinical Risk functions of the Medical Staff, as appropriate;
(c) Assist the Clinical Services in designing guidelines for privileging physicians in endoscopy procedures.

10.19.3 COMPOSITION
(a) Chairperson, appointed by the President of the Medical Staff, subject to Medical Executive Committee approval;
(b) 4-6 physicians privileged to perform endoscopic procedures;
(c) Representative from Nursing Service, without vote;
(d) Representative of Administration, without vote;
(e) Representative from Care Coordination, without vote;
(f) Individuals as appropriate by invitation.

10.20 TASK FORCES AND TEAMS
Task Forces and Teams may be determined as needed by the President of the Medical Staff, Clinical Service Chairperson, the Medical Executive Committee, the Clinical Service Executive Committees or the Standing Committees of the Medical Staff. A representative from Nursing Service and Administration will be appointed to attend.
These committees will be evaluated on an annual basis by the Medical Staff at the time of committee appointments to determine if these committees shall continue to function.

10.20.1 DESIGNATED TASK FORCES AND TEAMS
(a) The following teams or committees have been designated by the Medical Staff or Clinical Service Chairperson:
   ▪ Radiation Safety Committee
   ▪ Child At Risk Evaluation (CARE) Team
   ▪ Trauma/Critical Care Committee
(b) The purpose of the Committee will be outlined at the time of formation or appointment;
(c) These Task Forces and Teams will meet on an as needed basis as determined by the entity authorizing their existence;
(d) The composition of these Task Forces and Teams will be determined at the time of appointment.

10.21 CLINICAL SUBSERVICE MEETINGS
As appropriate, the Clinical Services may choose to meet in their subspecialty groups. These are to be for information exchange and shall not be designated as recognized official entities of the Medical Staff. All official business shall be conducted at the Clinical Service meetings.

10.22 CRITICAL CARE COMMITTEES
(a) Critical Care Committees may be appointed as needed by the Clinical Service Chairperson and report to the Executive Committee of the Clinical Service to their critical care specialty;
(b) The purpose of the Critical Care Committees is to develop and implement mechanisms to monitor and evaluate the care provided by the special care units. They are also required to develop and coordinate or participate in developing and coordinating and enforcing clinical policies and procedures for these areas.

11. MEETINGS
11.1. MEDICAL STAFF YEAR
The Medical Staff year shall be the period from January 1 to December 31 of each year.

11.2. MEDICAL STAFF MEETINGS
11.2.1. REGULAR MEETINGS
The regular meeting of the Medical Staff shall be held annually, at a time and place designated by the Medical Executive Committee, for the purpose of receiving reports from officers and committees, electing officers, and transacting other such business as may properly come before the meeting of the Medical Staff.

11.2.2. SPECIAL MEETINGS
Special meetings of the Medical Staff may be called at the direction of the Medical Staff President and shall be called by the Medical Staff President at the
request of the Medical Executive Committee or any ten members of the active staff by written request, or Board of Trustees, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.3. DEPARTMENT/SECTION MEETINGS

11.3.1. REGULAR MEETINGS

Regular meetings of each Department/Section shall be held at least quarterly, or more frequently as necessary to perform the functions of Department/Sections as specified in Article Nine of these Bylaws. The Sections shall meet as often as necessary to perform Section functions. Medical Staff, and invited guests, are able to attend Clinical Service meetings. Only Active members may vote. Executive Session may be convened upon approval of a majority present. Members of the Provisional and Active Staffs are not required to attend meetings, except as provided under Section 11.4.2.

11.3.2. SPECIAL MEETINGS

Special meetings of a Department/Section may be called at the direction of the Chairperson of the Department/Section and shall be called by the Chairperson or any three members of the active staff of the Department/Section by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.4. ATTENDANCE REQUIREMENTS

11.4.1. GENERALLY

Active staff members of the Medical Staff may attend meetings of the Department/Section to which they are assigned, and the annual general staff meeting. Attendance shall be considered at the time of reappointment when evaluating whether a Member has met the obligations associated with Medical Staff membership, unless excused by the Executive Committee of the Clinical Service or Department.

11.4.2. SPECIAL APPEARANCES

A Medical Staff Member or other individual with clinical privileges may be required to attend a meeting of a Medical Staff Committee for purposes of conducting peer review. Following receipt of proper notice, which is defined as seven (7) business days, of such an attendance requirement, failure to attend may be grounds for suspension, termination, or other actions on Medical Staff membership or clinical privileges.

11.5. MEETING PROCEDURES

11.5.1. NOTICE OF MEETINGS

Notice of the date, time and place of the annual Medical Staff meeting shall be given not less than seven (7) days or more than thirty-one (31) days prior to a regular meeting, and not less than three (3) days prior to a special meeting of the general Medical Staff by written notice delivered personally or sent by mail to
each Member of the active staff at his/her address as shown in Medical Staff records. The Medical Executive Committee or the Medical Staff President may send notice to members of other categories of the Medical Staff, the Chief Executive Officer, members of Administration and others. If mailed, notice shall be deemed to be delivered when deposited in the United States mail, postpaid.

Notice to a Medical Staff Member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting.

11.6. QUORUM

11.6.1. GENERAL STAFF MEETINGS

General and Special Staff Meetings – Those members of the Active Staff in good standing who are present at any regular or special meeting constitute a quorum for the transaction of any business under the Bylaws and any related Manual.

11.6.2. DEPARTMENT/SECTION OR SERVICE MEETINGS

Clinical Service, Departments, Committees or any other clinical unit meeting – Fifteen (15%) percent of the qualified voting members in good standing of the service, etc., but not fewer than three (3) members, constitutes a quorum for the transaction of any business under the Bylaws and any related Manual.

11.7. MANNER OF ACTION

The act of a majority of the voting members present at a general Medical Staff meeting at which a quorum is present shall be the act of the Medical Staff. The act of the majority of voting Department/Section members present at a Medical Staff Department/Section meeting at which a quorum is present shall be the act of the Department/Section.

11.8. VOTING RIGHTS

Only Active status active staff members have the right to vote.

11.9. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided.

11.10. MINUTES

The Secretary/Treasurer shall prepare minutes of each meeting of the Medical Staff, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the Secretary/Treasurer, approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of records and information. Each Department/Section Chairperson or Director shall ensure that minutes are prepared for their respective Department/Section meetings.

11.11. PROCEDURAL RULES

The Medical Staff President, or in his/her absence, the Medical Staff President-Elect,
shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert’s Rules of Order, as may be modified by the Medical Staff.

12. CONFIDENTIALITY, IMMUNITY AND RELEASE

12.1. AUTHORIZATIONS AND CONDITIONS

Any applicant for Medical Staff membership or clinical privileges and every Member of the Medical Staff or individual with clinical privileges shall agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

12.2. CONFIDENTIALITY OF INFORMATION

Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the Chief Executive Officer, Chief Medical Officer Administrative officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a Member of the Medical Staff, authorized representatives of the Staff, the Administration or the Board.

12.3. BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment /performance improvement activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, Department/Section, or committee is outside appropriate standards of conduct for this Medical Staff and shall be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach shall subject the individual responsible for a breach of confidentiality to disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

12.4. IMMUNITY FROM LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result
from or be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

12.4.1. Applications for appointment to the Medical Staff or for clinical privileges;
12.4.2. Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;
12.4.3. Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;
12.4.4. Hearing and appellate review;
12.4.5. Medical care evaluations;
12.4.6. Peer review evaluations;
12.4.7. Utilization review and resource management; and,
12.4.8. Any other Hospital, Department/Sectional, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person’s professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

12.5. RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff Member or individual with clinical privileges shall, by requesting or accepting membership or clinical privileges, release and discharge from loss, liability, cost, damage and expense, including attorney’s fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon the request of the Hospital or any officer of the Staff, execute a written release in accordance with the tenor and import of this Article.

12.6. SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

12.7. NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

12.8 – STATUTORY IMMUNITY

This section shall in no way limit the protections and immunities provided by Kansas
13. ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

13.1. MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions. The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards. The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations and Policies shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Medical Staff Rules and Regulations and Policies may contain the associated detail for provisions in the Medical Staff Bylaws. “Associated details” are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws.

The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and the Board of Trustees shall uphold the Medical Staff Bylaws that have been approved by the Board of Trustees.

13.2. EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

13.3. METHODOLOGY

13.3.1. MEDICAL STAFF BYLAWS

Upon the request of the Medical Executive Committee, or the Medical Staff President, or the Administrative Affairs Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. If the proposed revision is made by the Medical Executive Committee, the Medical Executive Committee shall first communicate the revision via written notice of the proposed change to all voting members of the Medical Staff no less than twenty (20) days prior to the meeting at which the Bylaws changes are to be voted upon. If the proposed revision is made by written petition of voting members of the Medical Staff, the Medical Staff members shall first communicate the revision via written notice of the proposed change to all members of the Medical Executive Committee no less than twenty (20) days prior to the meeting upon which the Bylaws changes are to be voted. The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s). If a quorum is present as described in Article

317 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c)
318 42 C.F.R. §482.12(a)(3), Interpretive Guidelines
319 MS.01.01.01
320 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c), MS.01.01.01
321 MS.01.01.01
322 MS.01.01.01
153
Eleven, Section 11.6.1, for the purpose of enacting a bylaw change, the change shall require an affirmative vote of greater that fifty percent (50%) of the members voting in person or by written ballot. In the event of a conflict within the Medical Staff regarding Medical Staff Bylaws, the Medical Staff process for conflict management shall be implemented. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff Policies, Medical Staff members shall be provided with a revised text.\textsuperscript{323}

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Trustees may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical Executive Committee of the urgent amendment within ten (10) days after the Board of Trustees has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to retrospectively review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Board of Trustees if necessary.\textsuperscript{324}

Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations, except as set forth below.\textsuperscript{325} As required by the Medicare Conditions of Participation and other regulatory requirements, the Board shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff.\textsuperscript{326} In the event of a documented need for an urgent amendment of the Medical Staff Bylaws in which the Medical Staff and the Medical Executive Committee are incapable of, or refuse to amend the Medical Staff Bylaws to comply with local, State or Federal laws and regulations, or to address a documented concern that could adversely affect patient safety or quality of care, the Board shall exercise its authority in such a situation to unilaterally amend the Medical Staff Bylaws or Rules & Regulations as necessary to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital after first exhausting reasonable efforts to gain the Medical Executive Committee’s or Medical Staff’s approval, including using the conflict management process as set out below in Section 13.5.9. In such a situation, the Board’s amendment shall be final, and all voting members of the Medical Staff shall be notified of the amendment within ten (10) days of the amendment becoming final.

13.3.2. RULES & REGULATIONS AND MEDICAL STAFF POLICIES

\textsuperscript{323}MS.01.01.01, MS.02.01.01, LD.03.04.01
\textsuperscript{324}MS.01.01.01
\textsuperscript{325}MS.01.01.03
\textsuperscript{326}42 C.F.R. §482.12
154
13.3.2.1. To implement the Medical Staff Bylaws, the Medical Staff shall develop administrative procedures, which shall be described in documents that supplement the Bylaws, such as Rules and Regulations, and Policies.

13.3.2.2. Medical Staff Rules and Regulations and Policies: Subject to approval by the Board, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Policies as may be necessary to implement these Bylaws. The Medical Staff also has the ability to adopt Rules and Regulations and Policies and any amendments thereto by obtaining a written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote. The Rules and Regulations and Policies proposed by petition shall then be communicated to the Medical Executive Committee and shall be subject to final approval of the Board. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governance Bylaws of the Board of Trustees.

13.3.2.3. Department/Section Rules and Regulations and Policies: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Board, each Department/Section shall formulate its own Department/Section Rules and Regulations and Policies for the conduct of its affairs and the discharge of its responsibilities. The members of the Department may also propose Department Rules and Regulations and Policies directly to the Board after first communicating the proposal to the Medical Executive Committee and such proposal shall be subject to final approval of the Board. Such Department/Section Rules and Regulations and Policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Policies of the Medical Staff or other policies of the Hospital and shall not conflict with the Governance Bylaws of the Board of Trustees.

13.4. TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations and Policies.

13.5. GENERAL PROVISIONS

13.5.1. SUCCESSOR IN INTEREST

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where hospital medical staffs are being combined. In the event that the staffs are combined, the medical staffs shall be governed by the Bylaws of this Medical Staff and shall remain in effect.

13.5.2. AFFILIATIONS
Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

13.5.3. NO IMPLIED RIGHTS

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

13.5.4. NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

13.5.5. NO CONTRACT INTENDED

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any Member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

Notwithstanding the forgoing, the provisions of Article Thirteen and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

13.5.6. CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in Department/Sectional activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting. This provision does not prohibit any person from voting for himself/herself.

13.5.6.1. When performing a function outlined in the Bylaws, applicable policies, or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another
individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

13.5.6.2. Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of Medical Staff President or Medical Staff Officer or the applicable Department/Section Chairperson or Committee Chair. The Medical Staff President or the applicable Department/Section Chairperson or Committee Chair will make a final determination as to whether the provisions in this Article should be triggered.

13.5.6.3. The fact that a Department/Section Chairperson or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.

13.5.6.4. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

13.5.7. NO AGENCY

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

13.5.8. CONFLICT

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

13.5.9. CONFLICT MANAGEMENT/RESOLUTION

13.5.9.1. CONFLICTS BETWEEN THE BOARD AND THE MEDICAL EXECUTIVE COMMITTEE

The Medical Staff, in partnership with the Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Board, or a
designated committee of the Board and Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Medical Staff President or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- One other Medical Executive Committee member
- The Chairperson, Vice-Chairperson, and Secretary of the Board or other designees of the Board
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Board within 30 days of the initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the Medical Staff President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical
13.5.9.2. CONFLICTS BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff’s recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Medical Staff President, the representatives of the Medical Staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Medical Executive Committee-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- Three voting members of the Medical Staff representing the recommendations in the written petition
- The Chairperson of the Board
- Chief Medical Officer, ex-officio with voice, but without vote
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The Medical Executive Committee and Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Medical Executive Committee and the Medical Staff shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and
the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the Medical Staff President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

13.5.10. ENTIRE BYLAWS

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.

CERTIFICATION OF ADOPTION AND APPROVAL

Approved and Adopted: Medical Staff – January 30, 2014
Approved and Adopted: Board of Trustees - March 20, 2014.