BAPTIST HEALTH DEACONESS

MADISONVILLE, INC.

MEDICAL STAFF BYLAWS

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TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

PART I. PREAMBLE, DEFINITIONS, PURPOSE OF A MEDICAL STAFF

PREAMBLE

These Bylaws provide the organization of the Medical Staff of Baptist Health Deaconess Madisonville, Inc. and a framework for self-governance and accountability of the Medical Staff in discharging its responsibilities in matters involving the standards for and appropriateness of medical care. As adopted by the Medical Staff, approved by the Hospital Board, and finally approved by the Governing Body, the Bylaws establish a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital.

DEFINITIONS

Medical Staff The physicians (MD and DO), dentists, podiatrists, and oral surgeons providing healthcare services in, or under the auspices of Baptist Health Deaconess Madisonville, Inc.
(BHDM) subject to the provisions of these bylaws. Such references as "Medical Staff organization" and "Medical Staff member" refer to organizational functions of the Hospital performed by practitioners.

Hospital Board This refers to the Board of Directors of Baptist Health Deaconess Madisonville, Inc., a Kentucky non-profit corporation of which Baptist Health Deaconess, LLC Board of Managers is the sole member and is charged with the appointment of persons to serve on the Hospital Board. Actions by the Hospital Board are effective when taken but may be subject to final approval by the Baptist Health Deaconess, LLC ("BHD") Board of Managers in accordance with the BHD Bylaw or as specified herein.

Allied Health Practitioner Allied Health Practitioner or "AHP" is an individual other than a licensed Doctor of Medicine, Osteopathy, Dentistry, or Podiatry who holds a license, certificate, or other legal credentials required by state law to provide patient care services. An Allied Health Practitioner is not eligible for appointment to, or membership in, the Medical Staff, but may be subject to credentialing and other requirements as set forth in Medical Staff policies, procedures and Related Documents.

Governing Body or BHD Board The term "Governing Body" means the Board of Managers of Baptist Health Deaconess, LLC under whose Bylaws the BHD Board finally approves actions by the Hospital Board with respect to: suspension, revocation, or termination of clinical privileges and Medical Staff membership; and, the approval of Medical Staff Bylaws and any amendments thereto.

Hospital President The individual appointed by the Hospital Board to act in its behalf in the overall management of Baptist Health Deaconess Madisonville, Inc.

Practitioners Clinicians, including physicians, podiatrists, and dentists, who provide services to patients in or under the auspices of Baptist Health Deaconess Madisonville, Inc.

Independent AHP Any duly qualified Allied Health Practitioner permitted under both federal and state law to provide patient care services without the clinical supervision of a duly

licensed Practitioner. The Hospital Board shall determine, in its discretion, which, if any, Allied Health Practitioner professional category is qualified and permitted to serve as an Independent AHP in the Hospital. Presently, the Hospital Board permits only the Allied Health Practitioner professional category of certified registered nurse anesthetist (CRNA) to provide patient care services in the Hospital as an Independent AHP.

Dependent AHP Any duly qualified Allied Health Practitioner professional category that is permitted by the Hospital Board to provide patient care services at the Hospital and the Allied Health Practitioner professional category is either: a) required under applicable licensure, certification, or other legal requirements to provide patient care services only under the clinical supervision of a duly licensed Practitioner; or b) applicable licensure, certification, or other legal requirements allow the provision of patient care services without the clinical supervision of a duly licensed Practitioner, but the Hospital Board has elected in its discretion not to designate the Allied Health Practitioner professional category as an Independent AHP at the Hospital.

Ex Officio By virtue of an office or position held, with voting rights unless otherwise specified.

Medical Staff Appointment Appointment to the Medical Staff, assignment to a staff category, and assignment to a clinical service department. Medical Staff appointment does not automatically confer specific Clinical Privileges.

Clinical Privileges Permission granted by the Hospital Board, acting upon Medical Executive Committee recommendations, to render specific types of care to inpatients and outpatients at Baptist Health Deaconess Madisonville, Inc. facilities.

Medical Staff Organization The formal structure which accomplishes specific organizational functions, including but not limited to continuing education, clinical review, providing recommendations to the Administrative Board concerning appointment and privileges for Medical Staff appointees, credentialing of Allied Health Practitioners, and providing coordinated input to administration and the Hospital Board on affairs related to patient care and/or to interests/concerns of practitioners.

Medical Executive Committee (MEC) The elected representatives of the Medical Staff, authorized to act on behalf of the Medical Staff except when otherwise specified. "Executive Committee" means MEC, unless the Executive Committee of the Hospital Board is specified.

Clinical Service Departments and Sections Clinical Service Department means a grouping of practitioners according to clinical activities and interests. Sections mean sub-divisions of a Clinical Service Department, established only when necessary by the Service Department with MEC and Hospital Board approval.

Completed Application An application for Staff Membership and/or Clinical Privileges, initial or renewal, which has been declared complete by a representative of the Credentials Committee and the **Hospital President** or their designees. A completed application must include any information the applicant has been called upon to provide, and validation/verification of that information.

Input "Contribution to a common effort." (Webster). A voice; an opinion clearly and objectively expressed, provided for the purpose of guiding decisions of authoritative bodies and individuals.

Adverse Recommendation/Decision A recommendation by the MEC that the

Hospital Board deny an applicant's request for Medical Staff Appointment, Reappointment, or specific Clinical Privilege(s), or a recommendation by the MEC that the Hospital Board terminate Medical Staff membership, or reduce or rescind the Clinical Privileges of a current staff member. This term also means that the Hospital Board makes a decision that denies, revokes, or restricts membership or Clinical Privileges. The "first adverse decision" refers either to a negative MEC recommendation, or to a negative Hospital Board action following a positive MEC recommendation.

Hospital In the context of this document, unless usage suggests otherwise, means Hospital Board plus executive or administrative staff and the Medical Staff.

Assignment In the context of staff categories, means acceptance of a task assigned the staff member, such as by the MEC or Medical Staff President.

Under the Auspices of In the context of these Bylaws, means in conjunction with services provided by and charged for by Baptist Health Deaconess Madisonville, Inc. as opposed to healthcare services provided by individual practitioners who use Baptist Health Deaconess Madisonville, Inc. facilities and services for their patients.

Gender Words of masculine gender include correlative words of the feminine gender unless usage indicates otherwise.

Related Documents Rules, Regulations, Policies, and Procedures pertaining to the administrative and clinical operations of the Medical Staff, the performance of its members, and additional details pertaining to these Bylaws may be stated in the form of a Related Document, such as the Credentialing Procedures Manual, or they may stand alone or be compiled with other similar documents.

Other documents (such as a User's Guide, and Methods descriptions) simply contain explanations, diagrams, forms, form letters, and examples, intended only to guide, instruct, and clarify.

ARTICLE I. PURPOSE AND STRUCTURE

I.1 The purpose of this Medical Staff is to bring the physicians and dentists who practice at Baptist Health Deaconess Madisonville, Inc. together into a cohesive body to promote quality care and to offer advice, recommendations and input to the Hospital President and the Hospital Board.

I.2 The Medical Staff is comprised of its members, whose rights and responsibilities are determined by defined membership categories. Members operate within a structure in which they are granted clinical privileges, on the basis of which they are also assigned to clinical service departments or to optional sections. Members elect officers (see Article IV.1) who, with Department Chairs, the Hospital President, the Vice President of Nursing, and the Chief Medical Officer, comprise the Medical Executive Committee. Executive functions of the Medical Staff are carried out by the Department Chairs, officers, and members of the Medical Executive Committee who operate under these Medical Staff Bylaws which are adopted by voting members of the Medical Staff and become effective upon approval by the Hospital Board, and subject to final approval by the Governing Body.

ARTICLE II. MEDICAL STAFF APPOINTMENT

II.1 GENERAL QUALIFICATIONS

Successful applicants for Medical Staff appointment must comply with the following:

- Current license to practice Medicine or Dentistry in the Commonwealth of Kentucky;

- Current valid federal drug enforcement registration certificate (if applicable to the applicant's practice and privileges requested);

- Successful completion of an ACGME, AOA or ADA accredited residency program. Dentists and oral surgeons must have graduated from an approved school of dentistry and satisfactorily completed an approved postgraduate training program of at least one year. If this criterion is not met, then the practitioner must be able to provide compelling evidence demonstrating that the residency program completed by the practitioner is equal to or greater than the ACGME,

  AOA or ADA residency. A review of the compelling evidence will be conducted by the department chair, Credentials Committee, Medical Executive Committee. The Board of Managers will make the final determination in granting the exception to criteria. In addition to residency and fellowship training appropriate to the applicant's discipline, the applicant must have achieved board certification in the specialty for which the applicant is requesting clinical privileges within five (5) years of completion of formal training.

- Each member of the medical staff and all other practitioners with delineated clinical privileges shall be board certified by the American Board of Medical Specialties, the American Osteopathic Association, the Commission on Dental Accreditation, Council of Podiatrists, or the American Association of Oral Maxillofacial Surgery. (Practitioner is defined in these bylaws as physician, dentist, oral surgeon, or podiatrist who has been authorized through licensure and the Hospital/Medical Staff to provide patient care services independently, without supervision.) If this criteria is not met, then the practitioner must be able to provide compelling evidence demonstrating that the board certification held by the practitioner is equal to or greater than that required by the American Board of Medical Specialties, the American Osteopathic Association, the Commission on Dental Accreditation, Council of Podiatrists, or the American Association of Oral Maxillofacial Surgery. (Practitioner is defined in these bylaws as physician, dentist, oral surgeon, or podiatrist who has been authorized through licensure and the Hospital/Medical Staff to provide patient care services independently, without supervision.) A review of the compelling evidence will be conducted by the department chair, Credentials Committee, Medical Executive Committee. The Board of Managers will make the final determination in granting the exception to criteria. Members of the House Staff completing post graduate training are not subject to the board certification requirement. This requirement for board certification is waived for those practitioners holding medical staff privileges at Hospital on or before August 19, 2014 who are not board certified and general dentists and podiatrists who are considered eligible for membership if duly licensed to practice in the State of Kentucky.

Applicants who are not board certified at the time of application but have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment and clinical privileges. To maintain eligibility, those applicants must attain board certification within five years from the date of completion

of the highest level of training. Failure to attain board certification within the five-year period shall result in a review of the physician's status in the board certification process conducted by the Credentials Committee. Following review, the Credentials Committee and Medical Executive Committee may recommend granting an extension to allow the practitioner to attain board certification. The Board of Managers shall make the final determination in granting the extension. Failure to attain board certification after the specified extension of time shall result in the automatic termination of the practitioner's medical staff membership and clinical privileges

Failure to meet applicable board certification requirements may be grounds for automatic termination of medical staff membership and clinical privileges. However, termination on such grounds shall not be considered an adverse action and shall not invoke a right to a hearing or appellate review under Article X of the Medical Staff Bylaws.

- All members whose board specialties require recertification will be required to maintain certification. Effective at the time of recertification, the American Board of Medical Specialties, American Osteopathic Association, American Board of Oral and Maxillofacial Surgery, Commission on Dental Accreditation, Council of Podiatrists, and the National Board of Physicians and Surgeons

  are acceptable sources for board recertification. If a certification is expired the staff member will have three (3) years to achieve certification.

- If the medical board certification of the medical staff member expires, it is the medical staff member's responsibility to notify the Medical Staff Office.

- Failure of a staff member to meet recertification requirements will be reevaluated by the Medical Executive Committee upon the recommendation of the Credentials Committee.

- Failure of a medical staff member to meet recertification requirements may result in loss of medical staff privilege.

- Prior and current clinical practice experience and competence to perform privileges requested, clinical results and utilization practice patterns documenting continuing ability to provide patient care services at an acceptable level of quality and efficiency;

- Good reputation and character, mental, physical, and emotional stability, and ability to work with and relate well to others, to the extent required by the provisions of these bylaws;

- Ability to read, write and understand the English language and to prepare medical record entries and other documentation in a legible manner;

- Professional liability insurance of a type and in an amount established by the Hospital Board;

- Willingness to cooperate with the Hospital in implementation and use of the Computerized Physician Order Entry ("CPOE") process and electronic health records ("EHR"); and

- Not having been suspended or excluded from participation in, and currently eligible and having the ability to participate in Medicare, Medicaid, or any other federally or state

funded health care program and not having been sanctioned for any misuse of any such program's funds.

II.2 EFFECTS OF OTHER AFFILIATIONS

No practitioner shall be automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because he is licensed to practice in this or in any other state, or because he is a member of any professional organization, or because he is certified by any clinical board, or because he is a member of a medical school faculty, or because he had, or presently has, staff membership or privileges at another healthcare facility or in another practice setting. Nor shall any practitioner be automatically entitled to appointment, reappointment or particular privileges merely because he had, or presently has, staff membership or those particular privileges at this Hospital.

II.3 ETHICS AND CONDUCT

Professional conduct shall be governed by the Code of Ethics of the American Medical Association and by the code of ethics promulgated by the practitioner's relevant specialty professional organization.

In addition, every practitioner, at the time of appointment and reappointment, and at any time during the appointment period, must demonstrate to the satisfaction of the Medical Executive Committee and Hospital Board, a willingness and capability, based on current attitude and evidence of performance, to work with and relate to other staff members, members of other
health disciplines, Hospital management and employees, patients, and the community in general, in a cooperative, professional manner appropriate to quality patient care.

II.4 NONDISCRIMINATION

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of: age; sex; race; creed; color; national origin; a handicap unrelated to the ability to fulfill patient care and required Staff obligations; or any other criterion unrelated to the delivery of quality patient care in an efficient manner in the Hospital facilities, to professional qualifications or to the Hospital's purposes, needs and capabilities.

II.5 BASIC RESPONSIBILITIES ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

Regardless of staff category, all staff members with Clinical Privileges must:

A. Provide timely and continuous care to their patients.

B. Insure that a medical history and appropriate physical examination is performed by a qualified physician, or a credentialed provider under the supervision of the responsible physician who is a member of the Medical Staff with appropriate clinical privileges, on all patients admitted for inpatient care or operative/invasive procedures in an inpatient or outpatient setting. Outpatient procedures being done in the operating room or a procedure requiring analgesia with sedation also require a history and physical. The history and physical examination must be completed no more than thirty (30) days before inpatient care or operative /invasive procedures, or twenty-four (24) hours after admission, When the history and physical are completed within

thirty (30) days before admission, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Histories and physicals must be completed and documented in compliance with applicable state and federal law and in compliance with Medical Staff policies pertaining to history and physical requirements which should be consulted for more detail.

C. Complete all other patients' medical records as required by law and by applicable Rules, Regulations, Policies or Procedures, including factors of timeliness, legibility and accurate content.

D. Be subject to the policies of the Clinical Service Department(s) in which privileges are held, and to the authority of the MEC and Hospital Board, through the chair of the service department to which the individual is assigned with relevant input of other service department chairs.

E. Participate in development of physician-specific non-economic performance data, including quality practice, accessibility, and attitude, and shall respond to reasonable suggestions, if properly presented by individuals with authority in the organized medical staff or their designees.

F. Respond to reasonable requests to perform necessary Medical Staff organizational functions.

G. Cooperate with procedures for renewing Clinical Privileges every three years.

H. Follow Bylaws, Rules, Regulations, Policies and Procedures.

I. Participate in the on-call coverage of the emergency services and other coverage programs as requested or determined by the specific service department chair or the Medical Executive Committee.

J. Observe and comply with Baptist Health Deaconess Madisonville Inc.'s standards of conduct and other applicable policies as set forth in the Corporate Responsibility Program.

K. Follow consultation policies which, except in emergencies, apply to the following situations:

1. When the patient's condition makes a second opinion on operative risk desirable.

2. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

3. In unusually complicated situations where specific skills of other practitioners may be needed.

4. In instances in which the patient exhibits severe psychiatric symptoms or suicidal tendencies and the patient is not under a psychiatrist's care.

5. When the patient or the patient's family requests a consultation.

6. In the critical care unit when a patient's needs exceed an independent

practitioner's privileges. In such circumstances, the physician obtains consultation from another licensed independent practitioner, who has documented requisite privileges to admit, treat, or manage this patient. These privileges are defined in each individual practitioner's delineation of privileges.

Documentation of Consult:

1. When a consult is requested, the reason for the consultation should be clearly stated.

2. If the consult is requested as routine, then the patient should be seen within twenty-four (24) hours.

3. If the consult is requested as urgent, the call should be made by the requesting physician calling the consulting physician personally and the timeliness of the consult can be negotiated between the referring and consulting physicians, based on the patient's acuity.

4. If a nurse believes that appropriate consultation is needed and such consultation has not been requested, **the nurse** should first contact the attending physician, and may consult with any of the following: superior, the Chief Nursing Officer, the Chair of the relevant Clinical Service or authorized designee.

In case of an emergency, any staff member, to the degree permitted by the staff member's license and regardless of staff status or Clinical Privileges, shall be permitted, but not required to assist in the care of the patient. For the purposes of this provision, "emergency" refers to a condition in
which serious or permanent harm might result to a patient, or in which the life of a patient might be in immediate danger, in the event of delay in administering treatment.

II.6 MEDICAL STAFF MEMBERS' RIGHTS

A. Each physician on the medical staff has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve a difficulty working with the respective service department chair, that physician may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

B. Any practitioner has the right to initiate a recall election of a medical staff officer and/or service department chair. A petition for such recall must be presented to the Medical Executive Committee, signed by at least 10% of the members of the active staff. Upon presentation of such valid petition, the Medical Executive Committee will schedule a special general staff meeting for purposes of discussing the issue and (if appropriate) entertain a no confidence vote and if appropriate follow the removal from office process.

C. Any practitioner may call a general staff meeting upon presentation of a petition signed by 10 % of the members of the Active Staff. The Medical Executive Committee will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

D. Any practitioner may challenge any rule, regulation or policy established by the Medical Executive Committee by submitting a petition signed by 10 % of the members of the active staff. When such petition has been received by the Medical Executive Committee, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issues.

E. Any section or subspecialists group may request a service department meeting when a majority of the members or subspecialists believe that the service department has not acted in an appropriate manner.

F. The above sections A-E do not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges or any other matter relating to individual membership or privileging sections. Article X which outlines the Hearing and Appeals process provides recourse in these matters.

II.7 TERM OF APPOINTMENT

Appointments to the Medical Staff and grants of clinical privileges are generally for a period not to exceed three (3) years, except under the circumstances specified in the Credentialing Procedures Manual.

II.8 PROCESS FOR APPOINTMENT AND REAPPOINTMENT

A. These Bylaws contain the basic steps for appointment and reappointment to the Medical Staff. Additional details are contained in the Credentials Policy and Procedure Manual which should also be reviewed.

B. In addition to meeting the general qualifications for Medical Staff appointment outlined in Section II.1 of these Bylaws, initial applicants must also meet the criteria described in the Credentials Policy and Procedure Manual, including demonstration of active clinical practice within the preceding twelve (12) months and adequate assurance of coverage response time if the applicant does not reside and practice in the Madisonville community or immediately surrounding area.

C. The applicant will be provided the appropriate application form to be completed and submitted to the Medical Staff President or designee. Applications must be signed by the applicant, thereby authorizing investigation of the applicant's background, credentials, and
qualifications and releasing those involved in the application and credentialing process from liability, all as further detailed in the Credentials Policy and Procedure Manual. Applications will not be considered until they have been declared complete by the Chair of the Credentials Committee and the Hospital President or their designees. If all information required to render the application complete has not been submitted within sixty (60) days after the applicant's receipt of the form, the application will be considered incomplete and no further processing will take place.

D. Information contained in the application will be appropriately verified. The burden is upon the applicant to provide all requested information. Failure to adequately respond to a request for assistance in obtaining additional information to support the application within sixty (60) days of a request will be deemed a voluntary withdrawal of the application.

E. Applicants for the Medical Staff may be required to participate in an interview at the discretion of the Credentials Committee. In any event, all applications are presented to the Department Chair for review and recommendation and a report to the Credentials Committee containing, among other things, the Department Chair's recommendation for approval or disapproval of the application. The Credentials Committee will then review the application and may vote to defer the application for further consideration or will make a recommendation to the Medical Executive Committee to approve or disapprove the application.

F. After review of the application and the recommendation of the Credentials Committee, the MEC may vote to defer action or will forward to the Hospital Board the MEC's recommendation for approval or disapproval of the application. In the event of an
unfavorable recommendation by the MEC on the application, the applicant shall be entitled to a hearing as provided in these Bylaws before any action is taken by the Hospital Board.

G. Favorable action by the Hospital Board on the MEC's recommendation for appointment or reappointment is effective as a final decision as of the first day of the month following the Hospital Board's approval. If the Hospital Board's action is adverse to the applicant, the applicant will be provided notice and the right to a hearing as described under these Bylaws.
Notice of the Hospital Board's final decision shall be given through the Hospital President to the MEC and to the Chair of each Department concerned. The applicant shall also receive written notice of appointment and notice of any adverse final decisions.

H. All initial appointments to the Medical Staff and grants of clinical privileges are provisional for a period of one (1) year during which time all individuals with provisional privileges may be subject to review of their clinical performance by their Department Chair. Subject to the approval of the Credentials Committee, the provisional period may be extended.

I. All appointments and reappointments to the Medical Staff are for a period not to exceed three (3) years. On or before four (4) months before the expiration of Medical Staff appointment, the Medical Staff Office will notify the appointee of the expiration date. At least ninety (90) days before expiration of the appointment, the practitioner is required to submit a completed reapplication including all information specified in the Credentials Policy and Procedure Manual. The practitioner has the burden of producing required information. The failure to provide required information shall be deemed voluntary resignation from the Medical Staff and automatically results in expiration of appointment unless an extension is granted for not more than two (2) meeting cycles of the Credentials Committee. Medical Staff Services shall collect information necessary to process the reapplication from appropriate internal and external sources. When all required information has been obtained, it will be submitted for review by the Department Chair or designee. Applications for reappointment are processed through the same procedures described above for the processing of applications for initial appointment. In addition, the Department Chair will be asked to provide relevant information concerning performance during the applicant's current appointment.

J. Whenever the Hospital Board makes a decision contrary to the Medical Executive Committee's recommendation on an application for appointment or reappointment, the matter will be submitted for conflict resolution in accordance with Article XII of these Bylaws.

II.9 PROCESS FOR CREDENTIALING AND RECREDENTIALING

A. These Bylaws contain the basic steps for appointment and reappointment to the Medical Staff. Additional details are contained in the Credentials Policy and Procedure Manual which should also be reviewed.

B. Each application for appointment or reappointment to the Medical Staff must contain a request for specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges or for a modification of privileges. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Medical Staff and as further described in the Credentials Policy and Procedure Manual. The procedure for processing requests for clinical privileges is the same as the process for appointment and reappointment applications.

C. Requests for clinical privileges from Allied Health Professionals are processed in the same manner as requests for clinical privileges by physicians, except that Allied Health Professionals are not eligible for membership on the Medical Staff and do not have the rights or privileges of such membership. Only those categories of Allied Health Professionals approved by the Hospital Board for patient care at the Hospital are eligible to apply for clinical privileges. All applications and requests for privileges from Allied Health Professionals will be distributed and processed by, or under the direction of, the Medical Staff Office. Details of the requirements of Allied Health Practitioners by professional category, including the divisions of Independent AHPs and Dependent AHPs, are further described in the Credentials Policy and Procedure Manual.

D. Under certain circumstances, temporary clinical privileges may be granted for a limited period of time not to exceed 120 days. Temporary privileges may be granted to fulfill an important patient care, treatment and service need or when an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body. Temporary privileges may be granted by the Hospital President or by the Chief Medical Officer or authorized designee upon written concurrence of the Chair of the Department, or Medical Staff President or authorized designee in which the privileges will be exercised.

E. In the case of emergency, any Medical Staff appointee, to the degree permitted by the Medical Staff appointee's license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician or dentist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of the section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

F. Disaster privileges may be granted when an incident command/emergency

management plan has been activated at the Hospital and the Hospital is unable to meet immediate patient needs. The Hospital President, or the Chief Medical Officer or the Medical Staff President, may sign and approve emergency credentialing privileges. Physicians and Allied Health Practitioners who present to the Hospital during an emergency must be directed to a designated location where privileges will be granted on a case by case basis at the discretion of the Hospital President or designee. Other volunteer practitioners who present to the Hospital during a disaster must be directed to the Medical Staff Office where temporary privileges may be granted on a case by case basis at the discretion of the Hospital President or designee. Physicians, Allied Health Practitioners and volunteers must present proof of qualifications as further described in Medical Staff policies pertaining to "Incident Command/Disaster Credentialing" which provide additional details regarding disaster privileges. Subject to appropriate verification, physicians, Allied Health Practitioners and volunteer practitioners will be logged in and will be granted privileges relative to their training and assigned to a credentialed practitioner currently on staff who has similar privileges whom they will accompany. Disaster privileges will automatically terminate when the disaster situation is declared resolved by the Hospital President or the Medical Staff President, or they may be automatically terminated at any time without cause. Termination of disaster privileges does not give rise to the right to a hearing.

G. Practitioners wishing to reinstate privileges after having been deemed to have resigned from the Medical Staff due to expired documents (e.g., required license, DEA certificate, insurance, or other certifications) must submit an application for reinstatement within six (6) months of the deemed resignation. Physicians reinstated more than six (6) months after deemed resignation will be required to serve in the Provisional category. Notification timelines and other details pertaining to reinstatement under these circumstances are described in greater detail by Medical Staff expiration policies.

H. Whenever the Hospital Board makes a decision contrary to the Medical Executive Committee's recommendation on an application for credentialing or recredentialing, the matter will be submitted for conflict resolution in accordance with Article XII of these Bylaws.

II.10 MEDICAL ADMINISTRATIVE OFFICERS

A medical administrative officer is a physician engaged by the Hospital either full or part-time to perform administrative duties, whose activities may also include clinical responsibilities such as direct patient care, teaching or supervision of the patient care activities of other physicians under the officer's direction.

Physicians with Hospital contracts whose duties include providing patient care must be members of the Medical Staff, and must obtain and maintain Clinical Privileges in the same manner as any other Medical Staff member.

Physicians with administrative duties may be appointed to the Medical Staff and may hold clinical privileges.

ARTICLE III. STAFF CATEGORIES

III.1 ASSIGNMENT AND GENERAL CHARACTERISTICS

Each appointee is assigned to a Staff Category by the MEC, upon recommendation of the Credentials Committee.

Assignment to a Staff Category, the primary purpose of which is to define membership prerogatives and obligations of a staff member, shall be made at the time of initial appointment to the staff. Changes in Staff Category assignment may be requested at any time by written request.

III.2 CATEGORIES OF THE MEDICAL STAFF

Active Physicians (MD and DO), dentists, podiatrists, and oral surgeons who attend, admit (inpatient or outpatient) or provide care or treatment for a minimum of 13 patients each year at the Hospital, can provide for continuous care to their patients, and who assume all the functions and responsibilities of membership on the Active Medical Staff. This category shall also include hospital-based physicians.

Any physician wishing to be active status may do so by documenting to the Credentials Committee the physician's efforts to support the patient care mission of Baptist Health Deaconess Madisonville, Inc.

Medical Staff members/appointees assigned to the Active Staff Category are entitled to vote and are eligible to hold office.

Medical Staff members/appointees assigned to the Active Staff Category must fulfill the obligation of on-call emergency care and backup coverage and follow policies set forth by the hospital's rules and regulations

Attendance of medical staff meetings is strongly encouraged.

Medical Staff members/appointees assigned to the Active Staff Category must accept and accomplish tasks assigned by the Medical Staff President, Medical Executive Committee, or Chair of the clinical service department to which the individual is assigned, and must meet other specific obligations and participate in the Emergency Services specialty call roster which can be determined by the Chair of the Department upon approval of the Medical Executive Committee.

Medical Staff members/appointees assigned to the Active Staff Category are expected to participate in quality assessment and monitoring activities including evaluating provisional appointees, as assigned by department or committee chairpersons.

Affiliate Physicians, dentists, oral surgeons and podiatrists who wish to have a formal affiliation with the Medical Staff of BHDM may apply for membership to the Affiliate Staff Category. The qualifications, requirements and application process for Affiliate Staff Category shall be the same as the process for Active Staff. Members of the Affiliate Staff who have requested and been granted delineated clinical privileges must provide consultation, admission (inpatient or outpatient), care or treatment of at least one patient but no more than 12 patients at BHDM each year.

The Affiliate Medical Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who meet the qualifications outlined in these Bylaws.

Affiliate Medical Staff members may exercise such clinical privileges as are granted to him/her by BHDM pursuant to these Bylaws. (Note: A member of the Affiliate Medical Staff is not required to apply for or hold delineated clinical privileges at BHDM.)

Members of the Affiliate Staff who have not been granted delineated clinical privileges at

BHDM are exempt from malpractice insurance minimums prescribed in the Medical Staff Bylaws, Rules and Regulations, and Policies.

Members of the Affiliate Staff who have requested and been granted delineated clinical privileges may, dependent upon the current staffing needs of the Hospital, be required to provide emergency on-call and back-up coverage.

Members of the Affiliate Staff may attend meetings of the general staff, as well as the department and/or section of which the physician is a member but shall have no voting rights.

Members of the Affiliate Staff may attend hospital continuing medical education programs.

Members of the Affiliate Staff may be appointed to a standing or ad-hoc committee, if appointment is determined to be of benefit to the committee, but may not serve as chair of a committee. Committee appointment may be with or without vote, at the discretion of the Medical Executive Committee.

Members of the Affiliate Staff may not hold office at any level of the medical staff organization.

House Staff The house staff shall consist of resident physicians who are enrolled in an accredited post-graduate medical training program that is approved the by Accreditation Council for Graduate Medical Education of the American Medical Association, and fellows are licensed in the Commonwealth of Kentucky and enrolled in a post-residency training program in the Commonwealth of Kentucky that is affiliated with an accredited medical school for specialty training and approved by the Accreditation Council for Graduate Medical Education of the American Medical Association.

Members of the House Staff shall not be eligible to vote or hold office, but they will be strongly encouraged to attend appropriate medical staff meetings.

The duties of the House Staff shall be to provide health care services to patients in accordance with their training assignments and in conjunction with members of the active staff.

Members of the House Staff shall work under the guidance of the Director of their respective training program and shall be supervised by the member(s) of the active medical staff to whom they are assigned for their training.

ARTICLE IV. OFFICERS AND MEETINGS

IV.1 LIST OF OFFICERS, TERMS, AND SUCCESSION

Officers are:	**Term**
Staff President	2 Year
President-Elect (Elected Bi-Annually)	2 Year
Immediate Past President	2 Year

Officers may not succeed themselves in the same office. Officers begin to serve on the first day of the calendar year.

IV.2 ELIGIBILITY REQUIREMENTS

Only Active staff members are eligible to be elected officers, and failure to meet the requirements of Active staff membership during the term of office results in automatic removal from office.

Officers shall not hold two offices simultaneously.

Officers shall not simultaneously be an officer on any other Medical Staff.

IV.3 NOMINATION, ELECTION, VACANCIES

A. **Nominations:**

A slate of officer candidates is selected by a nominating committee composed of the last three presidents of the Medical Staff (current past-president and previous two past presidents). The Staff President shall designate the Chairman of the Nominating Committee. One or more nominees shall be proposed for the office of President-Elect.

Nominations are allowed from the floor.

B. **Election:**

The President-Elect shall be elected at the Annual meeting of the Medical Staff, by a simple majority of staff members eligible to vote, and present. (A quorum is required per Section IV.8 of these Bylaws.)

C. **Vacancies:**

Vacancies in elected or appointed officer positions shall be filled (until the next regular election or appointment period) by a two-thirds vote of the Medical Executive Committee.

IV.4 REMOVAL OF OFFICERS

Failure of an officer to maintain Active staff status results in automatic removal from office.

In addition, the Medical Staff may, by a 2/3 majority vote at any regular staff meeting or at a special meeting duly called for this purpose, remove any Medical Staff officer for failure to fulfill responsibilities, malfeasance in office, physical or mental infirmity to a degree that renders the officer incapable of fulfilling the duties of the office, or conduct detrimental to the interests of the Hospital and/or Medical Staff. Neither the Hospital Board of BHDM nor the Board of Managers of BHD, nor their respective officers, as independent action, shall remove Officers of the Medical Staff organization.

IV.5 DUTIES OF OFFICERS AND AT-LARGE MEMBER

A. **President**

The President shall:

a. Act in coordination and cooperation with the Hospital President in all matters of mutual concern within the Hospital.

b. Call, preside at, and be responsible for the agenda of all general staff meetings of the Medical Staff.

c. Serve on the Medical Executive Committee and serve as its chairperson.

d. Serve as ex-officio member of all other Medical Staff committees.

e. Be responsible for seeking compliance of practitioners with Medical Staff and Hospital rules.

f. Appoint committee members to all standing, special, and multidisciplinary committees except as otherwise provided.

g. Present the views, policies, and needs of the Medical Staff to the Hospital Board and the Hospital President.

h. Interpret the policies of the Hospital Board to the Medical Staff, and report to the Hospital Board on non-economic performance and maintenance of quality care.

i. Be responsible for the educational activities of the Medical Staff.

j. Serve as a member of the BHDM Hospital Board.

B. **President-Elect**

In the absence of the President, the President-Elect assumes the duties and authority of the President. In addition, the President-Elect shall:

a. Serve on the Medical Executive Committee.

b. Automatically succeed the President when the latter fails to serve for any reason.

c. Succeed the President at the end of the President's term.

d. Provide for accurate and complete minutes of all Medical Staff meetings.

e. Call Medical Staff meetings on order of the President.

f. Provide for a record of attendance at meetings.

g. Attend to all correspondence on behalf of the staff.

h. Make minutes and correspondence available to the Hospital Board.

C. **Immediate Past President**

The Immediate Past President shall:

a. Serve on the Medical Executive Committee.

b. Perform such other reasonable duties as shall be assigned by the President or MEC.

c. May serve as chairperson of the Credentials Committee.

D. **At-Large Member**

The at-large member shall:

a. Serve on the Medical Executive Committee

b. Perform such other reasonable duties as shall be assigned by the President or MEC.

IV.6 MEETINGS OF THE GENERAL MEDICAL STAFF, OF CLINICAL SERVICE DEPARTMENTS, OPTIONAL SECTIONS, AND OF COMMITTEES

A. **General Medical Staff**

The general Medical Staff meets at least annually, plus on special call. One meeting is designated the Annual meeting, at which officers are elected.

Special meetings of the general Medical Staff may be called at any time by the Medical Executive Committee, Staff President, or by the Hospital Board, and are held at the time and place designated in the meeting notice.

B. **Clinical Service Departments and Optional Sections**

Clinical Service Departments meet as needed and as requested by the Chair of the Service Department.

Optional Clinical Sections meet as often as is necessary to transact their business and to provide educational opportunities to optional clinical Section members.

C. **Committees**

The Medical Executive Committee meets at least monthly; other Medical Staff committees meet as often as necessary to perform their assigned functions.

IV.7 NOTICE OF MEETINGS

Notice of all meetings of the general Medical Staff, of service Departments, and of committees shall be provided at least two weeks in advance, except for special emergency meetings called to deal with an urgent issue.

IV.8 QUORUM

For regular and special general staff meetings, a quorum shall be the number of staff members eligible to vote who choose to attend the meeting, except that at least ten percent (10%) of Active Medical Staff members must be present to transact business.

For clinical service departments and medical staff committees, a quorum shall be those present and voting, however a minimum of at least two (2) Active Staff members must be present.

For the Credentials Committee, a quorum shall be three (3) voting members. For the Medical Executive Committees, a quorum shall be the majority of the voting members.

IV.9 ATTENDANCE REQUIREMENTS

Attendance at General Medical Staff, committee and service department meetings shall not be required. Poor attendance at assigned committee meetings or at general medical staff or service department meetings for which a member has assigned duties may be cause for replacement on the committee or reassignment of duties.

Meeting attendance will not be used in evaluating medical staff members at the time of reappointment.

IV.10 MINUTES

Minutes of meetings include a record of attendance and actions taken. Minutes of staff meetings, committee meetings, meetings of Clinical Service Departments and of sections, shall be maintained in accordance with the BHD Record Retention Policy.

IV.11 MAJORITY VOTE

Except as otherwise specified, actions are by majority vote of active staff members present and voting.

IV.12 RULES OF ORDER

Wherever they do not conflict with these bylaws, the latest edition of Robert's Rules of Order shall be followed.

ARTICLE V. CLINICAL DEPARTMENTS AND OPTIONAL SECTIONS

V.1 ASSIGNMENT TO SERVICE DEPARTMENT

Each staff appointee may request membership in one Clinical Service Department by the recommendation of the Credentials Committee, and considering the wishes of the staff member (appointee), the MEC will assign membership in one Clinical Service Department. The Clinical Service Departments are: Emergency Medicine; Family Practice; Hospitalist Medicine; Internal Medicine (including Cardiology Section); Pathology; Pediatrics; Radiology; and Surgery (including Anesthesia and Gynecology Sections).

Service Department assignment does not automatically imply the granting of Clinical Privileges. The staff member may request and be granted Clinical Privileges in one or more of the other service departments/sections.

Changes in Service Department may be requested at any time by written request to the Credentials Committee for consideration.

The exercise of Clinical Privileges in each service department is subject to relevant policies, and to the authority of the chair of the service department to which the individual is assigned, with relevant input of other service department chairs, depending upon the nature of the individual's hospital practice.

Disagreement between service department chairs shall be resolved by the MEC, to the satisfaction of the Hospital Board.

V.2 CURRENT DEPARTMENTS AND OPTIONAL SECTIONS

The Medical Staff shall be organized by service departments for purposes of accomplishing Medical Staff functions as defined in the policies. A list of the current service departments and optional sections are found in the Organization and Functions Manual.

The Medical Executive Committee may recognize any group of practitioners who have organized themselves into an optional clinical section. Any clinical section, if organized, will not be required to hold regularly scheduled meetings, nor will attendance be required. Clinical sections are completely optional and may exist to perform any of the following activities: continuing education, grand rounds, discussion of policies, discussion of equipment needs, development of recommendations for service department chairs or the Medical Executive Committee; participation in the development of criteria for clinical privileges when requested by the Credentials or Medical Executive Committees; and discuss specific issues at the request of the Medical Staff President, Credentials or Medical Executive Committees.

V.3 ADDITIONAL DEPARTMENTS OR OPTIONAL SECTIONS

For the purpose of accomplishing Medical Staff organizational functions in the most effective and efficient manner, additional service departments, or optional clinical sections within service departments, may be established by the MEC.

V.4 DEPARTMENT CHAIRS

A. **Qualifications**

Service Department Chairs shall be members of the Active staff category, in good standing.

They shall be certified by the specialty board relevant to their practice and department responsibilities, unless this requirement is waived, in a specific instance, by the MEC and Hospital Board, as a result of comparable clinical competence that is affirmatively established through the privilege delineation process.

B. **Selection**

A nominating committee composed of the past three (3) service department chairs shall nominate the chair-elect and present to the service department members for their endorsement.

C. **Term and Succession**

Service Department Chairs shall serve a term of three (3) years, and may succeed themselves, if chosen to do so.

D. **Election**

The nominating committee shall present the slate to the service department members at the department meeting for vote.

E. **Vacancy**

Should a vacancy in the position of service department chair occur, a new chair is selected, by the procedure described above, as soon as is reasonably possible.

F. **Removal**

Removal of a service department chair may be initiated by a 2/3 vote of staff members (a) assigned to the service department and (b) eligible to vote and (c) present, at a regular or special meeting of the service department. Reasons for removal include: failure to fulfill responsibilities, malfeasance in office, physical or mental infirmity to a degree that renders the department chair incapable of fulfilling the duties of the office or conduct detrimental to the interests of the Hospital and/or Medical Staff. Removal is not final until acted upon by the Medical Executive Committee. Neither the Hospital Board of BHDM nor the Board of Managers of BHD, nor their respective officers, as independent action, shall remove any Clinical Service Department Chair.

G. **Responsibilities**

Each service department chair is responsible for, but not necessarily limited to, performance of the following:

a. Performance of those Medical Staff functions outlined in the Medical Staff Policies. In so doing, the provisions of these bylaws and related documents (such as Policies and Methods Manuals) shall be consistently followed.

b. All clinically related activities of the service department.

c. All administratively related activities of the service department, unless otherwise provided for by the Hospital.

d. Continuing surveillance of the professional performance of all individuals in the service department who have delineated clinical privileges.

e. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the service department.

f. Recommending clinical privileges for each member of the service department.

g. Assessing and recommending to the relevant Hospital authority off-site outside sources for needed patient care, treatment, and services not provided by the service department or the Hospital.

h. The integration of the service department or service into the primary functions of the organization.

i. The coordination and integration of inter-service department and intra-service department services.

j. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

k. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

l. The determination of the qualifications and competence of service department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

m. The continuous assessment and improvement of the quality of care, treatment, and services provided.

n. The maintenance of quality control programs, as appropriate.

o. The orientation and continuing education of all persons in the service department or service.

p. Recommendations for space and other resources needed by the service department or service.

V.5 PEER REVIEW DUTIES AND FUNCTIONS (Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation)

It is recognized and acknowledged that clinical service departments, services, committees, boards, study groups and hearing panels, whether authorized or established pursuant to these Medical Staff Bylaws, the medical staff policies or pursuant to the Hospital's Bylaws, shall be required from time to time to perform designated peer review duties and functions including, without limitation: (1) the review of an applicant's or member's credentials: (2) determination of whether a Practitioner should have clinical privileges or be appointed to membership: (3) determination of the scope and conditions applicable to privileges or membership: (4) recommendations or actions on the modification, suspension or termination of clinical privileges or membership: (5) the review and evaluation of the competence or professional conduct of a Practitioner, including such things as clinical competence, character, mental or emotional stability, physical condition, and ethics, which affect, or could adversely affect, the health or welfare of patients or which otherwise may adversely affect the quality and appropriateness of patient care; (6) corrective actions, including summary suspension; (7) hearings and appellate reviews; (8) quality improvement/assessment, including medical care evaluation; (9) utilization review; (10) other hospital, service department, service or committee activities related to appropriate patient care and professional conduct; and (11) requests for information from, and reports to the National Practitioner Data Bank, the Kentucky Board of Medical Licensure and any other state or federal agency from whom information may be sought or reports may be made as required by applicable laws, rules, regulations or these Bylaws.

When performing any of the above, or other designated peer review functions, such entities shall be deemed to be acting on behalf of the Hospital and the Hospital Board and shall be deemed to be a "professional review body" as that term is defined by the Health Care Quality Improvement Act of 1986.

Further, a professional review body, including but not limited to those entities described above, as well as any person who is a member, participant in, employee of, or who furnishes information, professional counsel, assistance or services to such professional review body including the Hospital Board, the Hospital, its officers and employees, shall be subject to all of the rights, protections and immunities to the fullest extent afforded by these Bylaws and by applicable state and federal statutes and regulations, including, but not limited to provisions of KRS.311.377 and the Health Care Quality Improvement Act of 1986. 42 U.S.C. §11101 et seg.

All minutes, reports, actions, recommendations, communications and proceedings of any such entity shall be subject to all privileges, confidentiality and reporting requirements of state and federal statutes and regulations applicable thereto.

Patient Safety Organization (PSO): The MEC, or other designated peer review committees, employees, or contractors of BHDM or BHD will be discussing and analyzing information that is Patient Safety Work Product (PSWP) and, therefore, privileged and confidential pursuant to

federal law. The Medical Staff, employees, and contractors of BHDM or BHD shall at all times maintain and observe the requirements of the established Patient Safety Evaluation System (PSES) policy and preserve the privileged and confidential nature of the information discussed within these meetings. BHDM and BHD strictly prohibits the disclosure of PSWP information to any person who is not employed by or maintains privileges with BHDM. Anyone responsible for the inappropriate disclosure of PSWP may be subject to civil monetary penalties for each disclosure pursuant to federal law and may be subject to disciplinary action by BHDM.

ARTICLE VI. COMMITTEES AND FUNCTIONS

VI.1 TYPES OF COMMITTEES

There shall be a Medical Executive Committee and a Credentials Committee. Other functions as described in the Medical Staff policies may or may not require separate established committee(s).

Such other permanent and temporary committees of the Medical Staff as may from time to time be necessary may be established by the MEC.

VI.2 MEDICAL EXECUTIVE COMMITTEE

A. **Composition**

The Medical Executive Committee consists of:

Voting Members

- Officers of the Medical Staff
- One at-large representative nominated and elected pursuant to Article IV
- Chairs of each Clinical Service Department

The President serves as the Chair of the MEC.

Non-Voting/Ex Officio Members

- Hospital President (Administrator), and designees
- Vice President of Medical Affairs/Chief Medical Officer
- Vice President of Nursing/Nurse Executive

B. **Duties**

The duties of the Medical Executive Committee (MEC), as delegated by the Medical Staff, are:

a. To represent and act on behalf of the Medical Staff between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

b. To coordinate the activities of and policies adopted by the Medical Staff, service departments, and committees.

c. To receive and act upon reports and recommendations from the service departments, committees and officers of the Medical Staff concerning accountability (Performance Improvement Initiatives) and other responsibilities.

d. To recommend to the Hospital Board at least the following:

- The Medical Staff's structure;
- The mechanism used to review credentials and to delineate individual clinical privileges;
- Recommendations for delineated clinical privileges for each eligible individual;
- The participation of the Medical Staff in organization performance improvement activities; • The mechanism by which Medical Staff membership may be terminated; and • The mechanism for fair hearing procedures.

e. To pursue corrective action to necessary conclusions in accordance with Article VII.

f. To make recommendations on the operations of the Hospital, including patient care needs such as space, staff and equipment.

g. To obtain Medical Staff cooperation to maintain accreditation and licensure status of the Hospital.

h. To participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

i. To resolve inter-service department disputes, when necessary and possible.

j. To initiate review and propose necessary revisions to the Medical Staff Bylaws for adoption by the Medical Staff.

k. To initiate review of, to accept recommendations from Department Chairs or from the President of the Hospital for adoption or amendment of, or to formulate, adopt, or amend on its own, Rules, Regulations, Policies or Procedures, and Related Documents as necessary to carry out functions and operations of the Medical Staff as described in Article VIII of these Bylaws.

l. To carry out such other functions as assigned or delegated by the Medical Staff.

C. **Meetings**

The Medical Executive Committee meets at least ten (10) times per year and maintains a record of its proceedings and actions in accordance with the BHD Record Retention Policy.

Ex officio members shall be entitled to attend meetings, except when the MEC meets in executive session. Ex officio members are not eligible to vote.

VI.3 CREDENTIALS COMMITTEE

The composition and duties of the Credentials Committee are described in the Credentialing Procedures Manual.

VI.4 ADDITIONAL MEDICAL STAFF FUNCTIONS

Additional Medical Staff functions are outlined in the Medical Staff Policies. Accomplishment of these functions may or may not require the existence of separate established committees.

VI.5 REPRESENTATION ON HOSPITAL COMMITTEES

Medical Staff members shall serve, as requested, on Hospital committees, councils, or teams dealing with matters that affect the Medical Staff (examples: Patient Care Council, Strategic Planning, Infection Control, Safety, etc.). Such committees shall operate in accordance with Hospital bylaws and any applicable policies and procedures.

VI.6 APPOINTMENT OF MEMBERS AND CHAIRS

All committee members and chairs are appointed and approved by the Medical Executive Committee. Non-medical staff members are subject to approval by the Hospital President or designee. Each committee chair has the right to participate in discussion of and to vote on issues presented to the committee.

VI.7 TERM, PRIOR REMOVAL AND VACANCIES

Each appointed committee member serves a two (2) year term unless the member resigns or is removed from the committee. Any committee member interested in serving longer than the two (2) year term may do so if the member has fulfilled the responsibilities required of committee members. Each chair of a committee should have served for at least a year on the committee or otherwise have experience in the functions assigned to the committee.

A medical staff member serving on a committee, except one serving ex officio, may be removed from the committee for failure to fulfill the required committee responsibilities, maintain him/herself in good standing as a staff member or by action of the MEC. A vacancy on any committee is filled for the unexpired portion of the term in the same manner in which the original appointment is made.

ARTICLE VII. QUESTIONS OF MARGINAL PRACTICE AND/OR BEHAVIOR, DISREGARD FOR RULES, PHYSICAL OR MENTAL IMPAIRMENT, UNETHICAL CONDUCT

VII.1 PROBLEM IDENTIFICATION

Confirmed and documented patterns or incidents that adversely affect, or could adversely affect, patients, the Medical Staff, the Hospital or its employees, are addressed by Clinical Service Department chairs, and/or the MEC and Hospital Board in a timely manner.

Problem identification relating to a practitioner's clinical judgment or skills, compliance with Hospital and/or Medical Staff rules, physical or mental status, ethical behavior or conduct, may be by information developed routinely in the course of non-economic performance evaluation activities, or by an incident report or by complaint from a Medical Staff member, patient, or Hospital employee.

If necessary for fact-finding purposes, or if requested by the affected practitioner, by any member of the Medical Staff, or by the Hospital President on behalf of the Hospital Board, in a written request to the MEC including grounds for the request, then a formal study (review, investigation) shall be conducted, unless the Medical Staff President determines that such formal study is not warranted. In the event that a formal study is warranted, then this procedure shall be used:

a. The staff President shall appoint an ad hoc study group (investigative committee) and shall designate its chairperson.

b. The initial meeting of this study group shall be held within three (3) business days of the decision to initiate this procedure.

c. The affected practitioner shall be informed by the chair of the respective service department of the existence of the study group, and may be invited to attend meetings of the study group.

d. Legal counsel should be asked to advise proper procedure, and to evaluate the appropriateness of any resulting recommendation.

e. Following its initial meeting, the study group either (a) is ready (has enough reliable information) to report its finding(s) and recommendation(s) to the MEC, or (b) obtains further information, from whatever sources, prior to making its findings and recommendations.

f. The report of the study group shall be considered at a meeting of the MEC, called solely for this purpose, within thirty (30) days or less of completion of the study group's report.

g. The MEC shall (a) accept the study group's finding(s) and recommendations(s), or (b) accept the finding(s) but make a different recommendation, or (c) if it cannot accept the study group's findings, ask for, obtain and review additional information before making a finding and recommendations.

The MEC shall act on the study group's report no later than fourteen (14) business days after receiving it, or no later than fourteen (14) business days after receiving additional requested information if (c) in the preceding paragraph is necessary.

If this procedure is used, it is not a Hearing, and should not be referred to as a Hearing (see Article X).

VII.2 MEDICAL STAFF'S OBLIGATION

The Medical Executive Committee, through responsible individuals:

a. Develops and evaluates reliable, objective information to determine whether there are reasonable grounds to conclude that a problem exists.

b. Brings the full authority of responsible officers, service department chairs, and committees to bear to resolve the issue in a timely manner.

c. Includes information about resolving the problem in the MEC's reports to the Hospital Board.

VII.3 HOSPTIAL BOARD'S OBLIGATION

The Hospital Board:

a. Reviews the MEC's conclusion about the presence or absence of a problem and, as necessary, the objective information upon which that conclusion is based.

b. Through the Hospital President, assures availability of resources, such as information systems and support personnel, legal counsel, consultants, etc., as necessary.

c. Assures the Medical Staff of its support for reasonable, good faith efforts to resolve the issue.

d. Reviews, questions, and approves, modifies, or refers back to the MEC, the resolution of the issue proposed/implemented by Medical Staff leaders.

e. Acts on MEC recommendations in a timely manner.

VII.4 CHOOSING A REMEDY

Resolution may be by one, or a combination of, several remedies, which shall be chosen after considering the urgency, recurrence, frequency and/or severity of the specific pattern or incident, as well as on whether or not an uncooperative attitude is encountered.

VII.5 RESTRICTION OF CLINICAL PRIVILEGES, REDUCTION IN STAFF CATEGORY, REMOVAL OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

Upon the recommendation of the MEC, the Hospital Board may restrict, modify, or rescind an individual's privileges for the purpose of restricting the potential of harm to patients, other Medical Staff members, the Hospital or its employees.

VII.6 PRECAUTIONARY SUSPENSION

In the event that an individual practitioner's action may pose a danger to the health and/or safety of any individual or to the orderly operations of the hospital, then any two (2) of the following individuals: the President of the Medical Staff, the chair of the Clinical Service Department of which the practitioner is a member, the President of the Hospital, the Chief Medical Officer, or the Hospital Board Chair, shall have the authority as independent action and as a precaution to suspend all or any portion of the Clinical Privileges of the Medical Staff member in question. Such suspension does not imply final finding of fact or responsibility for the situation that caused the suspension. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity and not a final professional review action.

Such precautionary suspension is immediately effective, is immediately reported to all the individuals named above, and remains in effect until another or further action is taken.

Immediately upon the imposition of a precautionary suspension, the appropriate service department chair or the Medical Staff President assigns to another Medical Staff member the responsibility for care of any hospitalized patients of the suspended individual.

As soon as practical, but in no event later than three (3) days after a precautionary suspension, the MEC shall convene to review the action. The affected practitioner may request to be present at this meeting, which is not a Hearing (see Article X) and is not to be construed as such.

Within thirty (30) days of the first date of the precautionary suspension, the MEC will determine whether to continue the suspension, or recommend other action pursuant to this Article. If the action taken or recommended entitles the affected practitioner to a Hearing, then the Hearing and Appeals Procedure (Article X) shall apply.

A precautionary suspension is not reportable to the National Practitioner Data Bank unless it exceeds thirty (30) days and is otherwise reportable to the National Practitioner Data Bank.

VII.7 AUTOMATIC EFFECTS OF ACTIONS OF STAFF MEMBERS

A. **Completion of Medical Records**

a. All portions of each patient's medical record shall be completed within the required time period as described by applicable policies.

Failure to do so (unless there are acceptable extenuating circumstances) automatically results in (i) the record being defined as delinquent, (ii) notification to the practitioner, and (iii) temporary suspension of admitting privileges until such time as the now delinquent record is completed.

b. Reinstatement to the Medical Staff is allowed upon completion of the delinquent record.

B. **Actions Affecting State License to Practice or DEA Registration**

If a practitioner's actions result in the practitioner's state license to practice or DEA registration being revoked, suspended, limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the individual, then Medical Staff Appointment and Clinical Privileges are automatically revoked, suspended or limited to the same extent, subject to re-application by the practitioner when/if the license is reinstated, or limitations are removed, whatever is the case.

C. **Lapse of Liability Insurance**

If a practitioner's liability insurance lapses or is canceled without renewal, then the practitioner's Medical Staff membership and Clinical Privileges are automatically suspended until the effective date of their new liability insurance coverage, unless otherwise determined by the Governing Body, after considering the input of the MEC and the Hospital Board.

VII.8 RIGHT TO HEARING AND APPEAL

Circumstances under which a Medical Staff applicant or member/ appointee is entitled to (a) a Hearing on a recommendation and/or (b) an Appeal of the Hospital Board's decision, and the specific procedure to be followed for Hearings and Appeal, are described in the Hearing and Appeal Procedure (Article X), which is part of this Medical Staff Bylaws document.

Automatic effects of individual actions (Article VII.7) do not entitle the individual to any Hearing or Appeal rights.

ARTICLE VIII. MEDICAL STAFF POLICIES

A. The process for adopting and amending Medical Staff Policies or Procedures is described below. Policies may be stated in Related Documents, such as the Credentialing Procedures Manual, they may stand alone, or they may be compiled with other policies. Policies pertain to administrative and clinical operations of the Medical Staff and the performance of its members to the extent the Policies Regulations are not in conflict with these Bylaws or with the Bylaws, Rules, Regulations, Policies and Procedures of the Hospital.

B. Agreement to abide by the Bylaws includes agreement to abide by any Policy included in Bylaws-Related Documents.

C. Existing Policies are deemed to continue in effect unless and until they are amended, replaced or deleted by action of the Medical Staff or by the MEC, as provided herein, which action shall become effective upon approval by the Hospital Board.

D. Policies may be formulated, proposed, adopted, amended, or deleted as follows:

    1. The Medical Staff may formulate and propose by a petition signed by at least ten percent (10%) of the voting members any new or amended Policies after first communicating same to the Medical Executive Committee for input. After

obtaining input from the MEC, such new or amended policies may be adopted by a majority vote of the Medical Staff at any regular or specially called meeting for that purpose and shall become effective upon approval by the Hospital Board.

2. Pursuant to authority delegated by the Medical Staff, the MEC, itself, may propose new or amended Policies. After submitting same to any affected Service Department or Committee and after communicating same to the Medical Staff for input, the MEC may adopt such new or amended Policies, copies of which shall be communicated to the Medical Staff, and which shall become effective upon approval by the Hospital Board.

3. In cases where the MEC documents in writing the need for an urgent amendment to rules and regulations necessary to be in compliance with legal, licensing or accreditation requirements, the MEC may provisionally adopt same without prior communication with the Medical Staff and such amendment shall be effective upon provisional approval by the Hospital Board. A copy of such amendment will immediately be communicated to the Medical Staff. Unless objection to the amendment is expressed to the MEC by at least ten (10) percent of the voting members of the Medical Staff within fourteen (14) days of its provisional effective date, it shall be finally approved.

4. If there is objection presented by a petition signed by at least ten (10) percent of the voting members of the Medical Staff to a provisionally adopted new or amended policy, then the Medical Staff shall have an opportunity to submit comment on the provisionally adopted amendment and, by majority vote at any regular or specially called meeting for that purpose, repeal or amend the provisional amendment.

5. In the event of a conflict between the MEC and the Medical Staff, evidenced by a majority vote of the MEC or by a petition signed by at least ten (10) percent of the voting members of the Medical Staff, regarding a proposed or adopted Policies, the Medical Staff President shall convene a meeting in an effort to resolve the conflict. The Medical Staff shall be represented at the meeting by three (3) of its members as designated by the petitioners. The MEC shall be represented at the meeting by an equal number of Medical Executive Committee members. The Medical Staff President shall preside over the meeting and will invite each side to exchange information relevant to the conflict with respect to which all parties will exercise good faith in an effort to resolve their differences, taking into account the designated roles and responsibilities of the Medical Staff and the Medical Executive Committee, leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution of the dispute may be achieved by a majority vote of those in attendance at the meeting. The Medical Staff President may vote or may abstain, but shall be called upon to vote in order to break any tie.

ARTICLE IX. ADOPTION AND AMENDMENT OF BYLAWS

The Medical Staff Bylaws, together with applicable Policies and Procedures, govern the conduct of the Medical Staff, are to be compatible with Hospital Bylaws, and are enforced by the Medical

Staff. New Bylaws or amendments to the Bylaws may be proposed by the MEC, by another committee of the Medical Staff, or by a petition signed by at least ten percent (10%) of the voting members of the Medical Staff; however, only the Medical Staff, itself, may adopt new or amended Bylaws which shall then be submitted to the Hospital Board and shall become effective when approved by the Hospital Board, but shall be subject to final approval by the Governing Body. Neither the Medical Staff nor the Hospital Board may unilaterally amend the Medical Staff Bylaws or rules and regulations. Proposed Bylaws or amendments to the Medical Staff Bylaws shall be published to all Medical Staff members eligible to vote at least thirty (30) days before a special or regular meeting of the Medical Staff at which the proposed Bylaws amendments will be voted upon.

The adoption of these Bylaws or a proposed amendment shall require a two thirds (2/3) majority vote of the members of the Active Medical Staff present at such a meeting provided that a quorum of the Medical Staff is present. Bylaws adopted or amendments so made shall be effective when approved by the Hospital Board, but shall be subject to final approval by the Governing Body.

These Bylaws and accompanying rules, regulations and policies will be reviewed for appropriateness, compliance and clarity by a committee of the Medical Staff at least every three (3) years. Such review will be conducted in good faith and in a reasonable, responsible and timely manner.

The Medical Executive Committee may make such non-substantive corrections to the Bylaws and Related Documents as are, in the committee's judgment, necessary to correct typographical errors; to reorganize or renumber; or, to correct grammar. Such corrections need not be approved by the entire Medical Staff or the entire Hospital Board but must be approved by the Hospital President with copies published to the Medical Staff and the Hospital Board.

ARTICLE X. HEARING AND APPEALS PROCEDURE

X.1 DEFINITIONS

A. **Hearing** means notice and an opportunity to be heard, in a formal proceeding, with some mechanism for making a verbatim transcript, following a recommendation or an action that is adverse to an applicant or Medical Staff member (whichever is applicable), by the Medical Executive Committee ("MEC"), or by the Hospital Board if it makes the first adverse decision.

B. **Appeal** means review, by an appellate review panel, of an adverse decision of the Hospital Board following a Hearing as provided in these procedures.

C. All defined terms appearing in the Medical Staff Bylaws ("Bylaws") shall have the same meanings in this Article X as they have in other portions of this Bylaws document, and are fully incorporated by this reference.

X.2 GROUNDS FOR HEARING/APPEAL

Only the following recommendations or actions by the MEC or the Hospital Board provide cause to request a Hearing or Appeal:

A. Denial of Medical Staff appointment or reappointment.

B. Denial of Clinical Privilege(s) or requested additional Clinical Privilege(s).

C. Decrease or restriction of Clinical Privileges.

D. Suspension of Medical Staff appointment or of Clinical Privileges for more than thirty (30) days.

Neither voluntary nor automatic relinquishment of Clinical Privileges, as provided for elsewhere in these bylaws, shall constitute grounds for a Hearing, but shall take effect without Hearing or Appeal.

X.3 NOTICE, AND REQUEST FOR HEARING AND APPEAL

A. **Notice of Adverse Action or Recommendation:** When the MEC or Hospital Board makes a recommendation or takes an action which, according to these Bylaws, entitles an applicant or Medical Staff member (whichever is applicable) to a Hearing, he shall promptly be given written notice by the Hospital President by certified mail, return receipt requested. The notice shall include a statement of the specific recommendation or action taken and the reason(s) for the recommendation or action. The notice shall also include a summary of the individual's Hearing rights under these procedures.

B. **Request for Hearing:** The applicant or Medical Staff member (whichever is applicable) has thirty (30) days following receipt of the notice referred to in Paragraph A. above to request a Hearing. The request must be in writing, by certified mail, return receipt requested, to the Hospital President. The request must be postmarked on or before the 30th day following the individual's receipt of the Notice referred to in Paragraph A. above. If a Hearing is not requested within thirty (30) days, the applicant or Medical Staff member (whichever is applicable) has waived his right to Hearing and has accepted the recommendation or action, which becomes effective immediately.

B. **One Hearing and Appeal:** No applicant or Medical Staff member shall be entitled to more than one Hearing and one Appeal upon the same issue or issues.

X.4 THE HEARING: PROCEDURAL DETAILS

A. **Arrangements for the Hearing** the Hospital President after consultation with the Medical Staff President shall schedule the Hearing and provide written Notice of the Hearing, by certified mail, return receipt requested, to the applicant or Medical Staff member (whichever is applicable) who requested the Hearing. The Hearing shall not be held less than thirty (30) days after the date of the Notice, but will be held as soon thereafter as possible, considering the schedules and availability of all persons involved in the Hearing process. If the applicant or Medical Staff member refuses to agree to the hearing date within twenty-one (21) days of notice, then the applicant or Medical Staff member shall be deemed to have waived the right to a hearing. The Notice of Hearing shall include:

(1) The date, time, and place for the Hearing;
(2) A written description of the recommendation or action;
(3) A statement of the reasons for the recommendation or action, including those acts, omissions, charges or violations which serve as the grounds for the recommendation or action;
(4) The identification of any relevant patient records;
(5) Any other relevant information supporting the recommendation or action;
(6) A list of witnesses (if any) expected to testify at the Hearing on behalf of the MEC or Hospital Board; and;

(7) Name and address of Hospital attorney.

No later than fifteen (15) days before the Hearing, the applicant or Medical Staff member (whichever is applicable) who requested the Hearing shall advise the Hospital President in writing of the following:

(1) The name and address of his or her attorney, if any;
(2) A brief statement of the reasons for objecting to the recommendation or action;
(3) The identification of any relevant patient records; and
(4) A list of witnesses (if any) expected to testify at the Hearing on behalf of the applicant or Medical Staff member.

The statement and attached information may be amended or added to at any time, even during the Hearing, if additional material is relevant to the Hearing, and provided that the opposing party had sufficient time to study the additional information and offer a response.

B. **Presiding Officer:** The Hospital President may, after consulting with the Hospital Board Chairperson and with the Medical Staff President, appoint a presiding Hearing officer. The Presiding Officer may not be in direct economic competition with the person requesting the Hearing, and may not have been involved as a member of the MEC or Hospital Board which made the adverse recommendation (MEC) or took the adverse action (Board) which occasioned the Hearing. The Presiding Officer may be an attorney, but in any event must not act as a prosecuting officer or as advocate for the MEC or Hospital Board.

The Presiding Officer may participate in the private deliberations of the Hearing Panel, and may provide legal advice to the Panel, but is not entitled to vote on the Panel's recommendations.

If no Presiding Officer is appointed, the designated Chairperson of the Hearing Panel shall serve as the Presiding Officer. If the Chair of the Hearing Panel serves as Presiding Officer, the Chairperson may participate in the private deliberations of the Hearing Panel and may vote on the Panel's recommendation(s).

The Presiding Officer ensures that all Hearing participants have a reasonable opportunity to be heard, maintains order, determines the order of procedure of the Hearing in accordance with these Bylaws, and makes rulings on questions pertaining to matters of procedure and admissibility of evidence. The Presiding Officer shall be concerned at all times that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Hospital Board.

The Presiding Officer may take official notice of any generally accepted technical or scientific matter relating to the issue under consideration at the Hearing and of any fact which may be judicially noticed by the courts of this State. Participants in the Hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the Hearing. The applicant or Medical Staff member requesting the Hearing shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Panel. The Hearing Panel shall also be entitled to consider any pertinent material contained on file in the hospital, including information, which may be considered in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges pursuant to these Bylaws.

C. **The Hearing Panel:** The Hospital President, after considering the recommendations of the Medical Staff President and Hospital Board Chair, shall appoint a Hearing Panel of not less than five (5) members, the majority of whom will be physicians, and at least one of whom shall be a member of this Medical Staff assigned to the Active Staff Category. Knowledge of the matter being considered does not preclude appointment to the Hearing Panel, but Medical Staff members who have actively participated in the consideration of the matter at any previous level are not eligible for appointment to the Hearing Panel. No member of the Hearing Panel shall be in direct economic competition with the person requesting the Hearing. A Hearing Panel chairperson is designated by the Hospital President, after considering the recommendations of the Hospital Board Chair and the Medical Staff President.

D. **Representation:** The applicant or Medical Staff member (whichever is applicable) requesting the Hearing may be represented by an attorney, or other person of the individual's choice, who shall enter his appearance in writing with the Hospital President at least fifteen (15) days prior to the date of Hearing. The Hospital (which under these Bylaws refers collectively to the Medical Staff and Hospital Board) may be represented by legal counsel in all Hearings and proceedings under this Article X, and shall be represented by legal counsel if the affected applicant or Medical Staff member is represented by legal counsel. Counsel for the Hospital shall enter his appearance in the same manner.

E. **Specified Rights:** The person requesting the Hearing and the Hospital may:

1. Call and examine witnesses;

2. Introduce exhibits;

3. Cross-examine witnesses on matters determined by the Hearing Panel or Presiding Officer to be relevant to the issues;

4. Provide rebuttals at the Hearing for any evidence presented, and;

5. Submit a written statement at the close of the Hearing.

Even if the person requesting the Hearing decides not to participate on their own behalf, he may still be called as a witness.

F. **Burden of Proceeding:** The MEC or the Hospital Board, whichever made the recommendation (MEC) or decision (Hospital Board) that initially prompted the Hearing, must come forward with evidence in support of its recommendation (MEC) or action (Hospital Board). Once this obligation is fulfilled by the MEC or the Hospital Board, the person requesting the Hearing must come forward with evidence to refute the recommendation (MEC) or action taken (Hospital Board) which occasioned the Hearing.

The Hearing Panel shall recommend in favor of the MEC or Hospital Board (whichever group's action occasioned the Hearing) unless the Hearing Panel finds that the applicant or Medical Staff member (whichever is applicable) who requested the Hearing has proved that the recommendation (MEC) or decision (Hospital Board) that prompted the Hearing was arbitrary, capricious, unreasonable, or not supported by substantial evidence.

G. **Admissibility of Evidence:** Any evidence shall be admitted by the Presiding Officer at the Hearing which is relevant to the issues before the Hearing Panel and is the sort of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs without regard to the admissibility of such evidence in a court of law. The Hearing Panel may itself question witnesses, call additional witnesses, and request documentation of charges or claims made.

H. **List of Witnesses:** At least fifteen (15) days in advance of the Hearing, each party must provide the other with a written list of names and addresses of witnesses to be called. The witness list of either party may be amended at any time before or during the course of the Hearing for good cause.

I. **Failure to Appear:** If the applicant or Medical Staff member requesting the Hearing, fails to appear at the time the Hearing is scheduled, without good cause as determined by the Hearing panel, such failure constitutes a waiver of the right to a Hearing and a voluntary acceptance of the recommendation(s) (MEC) or action(s) (Hospital Board) pending, which then become effective immediately.

J. **Postponements and Extensions:** Postponements and extensions may be requested by any of the participants, but will be permitted by the Hearing Panel only for good cause.

K. **Hearing Record:** A record of the Hearing will be maintained by a court reporter retained by the Hospital. Copies of the record may be obtained by the applicant or Medical Staff member upon request and payment of any reasonable charges associated with its preparation.

L. **Attendance by Panel Members:** A simple majority is required in order for the Hearing Panel to proceed, and the final recommendation and report of the Hearing Panel must be approved by a majority of all the members appointed to the Hearing Panel.

M. **Conclusion of the Hearing Procedure:** After both parties have concluded their presentation of oral and written evidence, the Hearing is closed. At the close of the Hearing, the applicant or Medical Staff Member and Hospital may submit a written statement.

N. **Recommendation:** Within twenty (20) days after conclusion of the Hearing, and following any private deliberations that may be necessary, a recommendation and a report containing the reasons for the recommendation shall be prepared by the Hearing Panel and delivered to the Hospital President. The recommendation must be based on the evidence produced at the Hearing and may recommend confirmation, modification, or rejection of the original adverse recommendation or action. The supporting evidence may be stated as factual findings of the Hearing Panel.

Upon presentation of its report and recommendation, the Hearing Panel's obligation is fulfilled.

O. **Further Distribution of Hearing Panel Report and Recommendation:** The Hospital President shall send a copy of the Hearing Panel's report and recommendation, by certified mail, return receipt requested, to the person who requested the Hearing, and to the Hospital Board Chairperson.

P. **Hospital Board Consideration:** Based on the recommendation and report of the Hearing Panel, the Hospital Board may confirm, modify, or reject the adverse recommendation or action which prompted the Hearing, or refer the matter back to the Hearing Panel for further review.

The Hospital Board will make its decision within fourteen (14) days after the Hospital Board Chairperson receives a copy of the Hearing Panel's recommendation and report.

When the Hospital Board requests that the Hearing Panel further review the matter, the Hearing Panel will report back to the Hospital Board within thirty (30) days, unless a reasonable extension is granted by the Hospital Board. The Hospital Board will then make its decision within fourteen (14) days after receiving the Hearing Panel's additional report. Within five (5) days following the Hospital Board's decision, the Hospital President shall send a copy of the decision, including a statement as to the basis for the decision, to the affected applicant or Medical Staff member (whichever is applicable) by certified mail, return receipt requested.

X.5 APPELLATE REVIEW DETAILS

A. **Request for an Appellate Review:** Within thirty (30) days after receiving notice of an adverse decision by the Hospital Board following the Hospital Board's consideration of a recommendation and report of the Hearing Panel, the applicant or Medical Staff member may request an appellate review. This request must be in writing, delivered to the Hospital President, by certified mail, return receipt requested, and must include a brief statement of the reasons for the appeal. The following reasons will be considered by the Appellate Review Panel and shall be the only grounds for reversing an adverse action or recommendation:

1. Substantial failure by the Medical Executive Committee, Hospital Board, or a Hearing Panel, to comply with these bylaws in the conduct of proceedings affecting the applicant or Medical Staff member (whichever is applicable); or

2. The recommendation or action taken was arbitrary, capricious, or unreasonable, or;

3. The decision of the Hospital Board was clearly erroneous or not supported by sufficient evidence.

If appellate review is not requested within the thirty (30) day time period, the applicant or Medical Staff member (whichever is applicable) has waived the right to Appeal and has accepted the Hospital Board's decision.

B. **Arrangements for Appellate Review:** When an Appeal is requested, the Hospital Board Chairperson, or designee, within ten (10) days of receiving such request, shall schedule and arrange for an appellate review. The Hospital Board Chairperson shall provide to the applicant or Medical Staff member (whichever is applicable) notice of the date, time and place of the appellate review. The date for appellate review must not be less than thirty (30) days after the request is received. When the individual appealing is under suspension, then the appellate review is held as soon as arrangements can reasonably be made, but not more than fourteen (14) days from receiving the appeal request. The stated times within which appellate review must be accomplished may be extended by the Hospital Board Chairperson for good cause.

C. **Appellate Review Panel:** The Hospital Board Chairperson shall appoint an Appellate Review Panel of three (3) persons, which may include a member of the Hospital Board and may include a member of the Medical Staff assigned to the Active Staff Category. The Appellate Review Panel may not include any person in direct economic competition with the applicant or

Medical Staff member who is the subject of the appellate review. A Panel Chairperson will be designated by the Hospital Board Chairperson. D. Appellate Review Procedure:

1. The Appellate Review Panel shall review the record upon which the adverse recommendation or action was made and any written statements or oral testimony allowed or permitted pursuant to subparagraph (2) below. The Appellate Review Panel's function is not to act as a Hearing Panel and re-hear evidentiary presentations. The sole function of the Appellate Review is to review the record created at the Hearing, and any other evidence allowed or permitted by

   this Section, to determine whether the affected practitioner has established any of the grounds for Appeal set forth in Section XI.5.A.

2. Both the affected applicant or Medical Staff member and the Hospital shall have the right to present a written statement in support of their position on Appeal. The Appellate Review Panel, at its sole discretion, may allow a representative of each party to attend a meeting of the Appellate Review Panel to make a presentation on the matter under consideration, and to respond to questions by the Appellate Review Panel.

3. New or additional information not raised during the original Hearing, in the Hearing Panel recommendation and report, or otherwise reflected in the record, shall only be introduced during the appellate review under unusual circumstances. The Appellate Review Panel shall, at its sole discretion, determine whether such new information will be accepted. The Appellate Review Panel's decision must be based solely on information either in the record or presented at the appeal proceeding.

4. At the conclusion of the appeals proceeding, the Appellate Review Panel will issue a recommendation to the Hospital Board which states the basis for the recommendation. The Appellate Review Panel shall confirm the recommendation of the Hospital Board unless it determines that the applicant or Medical Staff member (whichever is applicable) has established one of the grounds set forth in Section XI.5.A. above.

5. During the period when an appeal is pending before the Appellate Review Panel, the Hospital Board's prior decision shall be in full force and effect unless otherwise determined by the Appellate Review Panel.

E. **Hospital Board Consideration:** The Hospital Board may accept, modify, or reject the recommendation of the Appellate Review Panel. The Hospital Board may, for good cause, request further review by the Appellate Review Panel, but the Hospital Board shall not function as another appellate forum. When further review is necessary, the Appellate Review Panel shall report back to the Hospital Board within thirty (30) days, unless a reasonable extension is granted by the Hospital Board. The final Hospital Board decision will be made within thirty (30) days after conclusion of the appellate review process. Within (10) days after the final Hospital Board decision, the Hospital President shall send notice of the decision stating the basis for the decision to the affected applicant or Medical Staff member (whichever is applicable) by certified mail, return receipt requested.

The decision of the Hospital Board following the appeal is effective immediately, and not subject to further review except for final approval by the Governing Body.

F. **Only One Appeal:** There is no exception to the rule that the applicant or Medical Staff member is entitled to only one appellate review of any single matter.

G. **Reapplication Following Adverse Decision on Appellate Review:** If the final decision of the Hospital Board and the Governing Body, following appellate review, are adverse, the applicant or Medical Staff member may reapply for appointment to the Medical Staff, or for the denied clinical privileges, whichever is applicable, one (1) year or later from the Hospital Board's decision, unless the Hospital Board provides otherwise in its final written decision.

H. **Following the Appeal:** The decision of the Hospital Board following the Appeal is effective immediately and final, and is not subject to further Hearing and appellate review except for final approval by the Governing Body.

ARTICLE XI. IMMUNITY FROM LIABILITY

XI.1 OBLIGATION TO PARTICIPATE IN AND TO WAIVE CLAIMS FOR PEER REVIEW

A. It is recognized and acknowledged that clinical service departments, services, committees, boards, study groups and hearing panels, whether authorized or established pursuant to these medical Staff Bylaws, the policies or pursuant to the Hospital's Bylaws, shall be required from time to time to perform designated peer review duties and functions including, without limitation: (1) the review of an applicant's or member's credentials; (2) determination of whether a Practitioner should have clinical privileges or be appointed to membership; (3) determination of the scope and conditions applicable to privileges or membership; (4) recommendations or actions on the modification, suspension or termination of clinical privileges or membership; (5) the review and evaluation of the competence or professional conduct of a Practitioner, including such things as clinical competence, character, mental or emotional stability, physical condition, and ethics, which affect, or could adversely affect, the health or welfare of patients or which otherwise may adversely affect the quality and appropriateness of patient care; (6) corrective actions, including summary suspension; (7) hearings and appellate reviews; (8) quality improvement/assessment, including medical care evaluation: (9) utilization review; (10) other hospital, service department, service or committee activities related to appropriate patient care and professional conduct; and (11) requests for information from, and reports to the National Practitioner Data Bank, the Kentucky Board of Medical Licensure and any other state or federal agency from whom information may be sought or reports may be made as required by applicable laws, rules, regulations or these Bylaws.

B. It is further recognized and acknowledged by all Practitioners who apply for or who have been granted clinical privileges or medical staff membership by the hospital that they may be called upon, from time to time, to participate in a peer review process including, but not limited to, those activities described in paragraph A, above. All Practitioners therefore acknowledge that it is in the mutual best interest of all Practitioners, as a condition of each Practitioner's application for, or exercise of clinical privileges to agree, and each Practitioner is hereby deemed to agree, to grant absolute immunity from civil liability and to waive any claim for damages against any person as a member, participant in or employee of , or who furnishes information, professional counsel, or services to any professional review body or entity referred to in Article V.5 of these Bylaws,

including the Hospital Board, the Governing Body, the Hospital and its officers and employees, for any good faith action or omission in the performance of any peer review duty or function and for any action taken or recommendation made in a reasonable belief that such recommendation or action is in the furtherance of quality health care.

C. All proceedings, records, opinions, conclusions and recommendations of a professional review body in the course of peer review activities shall be confidential and privileged to the fullest extent permitted by law.

D. Any Practitioner who is the subject of any peer review activity or peer review action by a professional review body, by applying for or accepting medical staff membership or clinical privileges, is hereby deemed to agree to hold harmless those entities and persons described in paragraphs A and B from all claims and damages, and from all reasonably incurred attorneys' fees and expenses, arising out of or related to any civil action threatened or commenced by such Practitioner, except as to any person or entity described in paragraph A or B who or which is found by the court to have acted in bad faith.

XI.2 CONFIDENTIALITY

Except as to such disclosure or release as may be required or authorized by applicable law, regulation or these Bylaws, members of the Medical Staff and the Hospital and its representatives shall respect and preserve the confidentiality of all communications and information relating to the review and evaluation of the competency and professional conduct of practitioners, and the monitoring and maintaining of appropriate patient care including, but not limited to, the confidential and privileged status afforded professional review functions by KRS §311.377.

XI.3 CUMULATIVE EFFECT

The provisions of this Article XI, and other provisions of these Bylaws relating to authorizations, releases, confidentiality, and immunities from liability are cumulative in nature and shall not in any manner be construed as limiting. Further, the protections provided by this Article XI and these Bylaws are in addition to any other protections that may be provided by law.

XI.4 CONFLICT RESOLUTION PROCESS

A. In the event of a conflict between the MEC and the Medical Staff, evidenced by a majority vote of the MEC or by a petition signed by at least ten (10) percent of the voting members of the Medical Staff, regarding a proposed or adopted Rule or Regulation, the Medical Staff President shall convene a meeting in an effort to resolve the conflict. The Medical Staff shall be represented at the meeting by three (3) of its members as designated by the petitioners. The MEC shall be represented at the meeting by an equal number of Medical Executive Committee members. The Medical Staff President shall preside over the meeting and will invite each side to exchange information relevant to the conflict with respect to which all parties will exercise good faith in an effort to resolve their differences, taking into account the designated roles and responsibilities of the Medical Staff and the Medical Executive Committee, leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution of the dispute may be achieved by a majority vote of those in attendance at the meeting. The Medical Staff President may vote or may abstain, but shall be called upon to vote in order to break any tie.

B. Whenever the Hospital Board determines that it will decide a matter contrary to a recommendation or proposal by the Medical Executive Committee or by the Medical Staff, upon a request by the majority of the Medical Executive Committee, or upon a request by a petition signed by at least ten (10) percent of the voting members of the Medical Staff, the Chair of the Hospital Board shall empanel a committee to resolve the conflict and shall preside over all meetings of the committee. The Chair shall vote only if necessary to break a tie. In addition to the Chair, the committee shall include three (3) members of the Hospital Board. If the conflict is with the Medical Executive Committee, it shall be represented on the committee by three (3) members of the Medical Executive Committee of their choice. If the conflict is with the Medical Staff, the committee shall include three (3) members of the Medical Staff of their choice. In no event shall both the Medical Executive Committee and the Medical Staff have representatives on the committee. The initial purpose of the committee shall be to identify and define the nature of the conflict and gather information necessary for a full evaluation. Each side will be invited to exchange information relevant to the conflict with respect to which all parties will exercise good faith in an effort to resolve their differences, taking into account the designated roles and responsibilities of the Medical Staff, the Medical Executive Committee, and the Hospital Board, including leadership responsibilities of each of those as well as the safety and quality of patient care at the Hospital. The dispute shall be decided by majority vote.