MEDICAL STAFF BYLAWS

Medical Staff
Kettering Medical Center
Kettering, Ohio

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DEFINITIONS

Allied Health Practitioner" or "AHP" means an individual other than a licensed Physician (allopathic or osteopathic), Podiatrist, Dentist, or Psychologist who functions in a medical support role or who exercises independent judgment within the area of his or her professional competence and is qualified to render direct or indirect medical, surgical, nursing, dental, podiatric, or psychological care under the supervision of or in collaboration with a Practitioner who has been accorded privileges for such care in the Hospital. These AHPs may include, but are not limited to, physician's assistants, advanced nurse practitioners, or other individuals whose scope of practice has been recognized by the Hospital.

Appointee means a Practitioner who has been granted membership to the Medical Staff as defined by the assigned staff category.

Board of Directors or Board means the board of directors of Kettering Medical Center.

Chief Executive Officer/President or President/CEO means the individual appointed by the Board of Directors to act on its behalf in the overall management of the Hospital. The Medical Staff may rely upon all actions of the President/CEO as being authorized by the Board of Directors.

Chief of Staff means the individual elected by the Medical Staff to be the spokesperson for the Medical Staff and chair of the Medical Executive Committee.

Clinical Privileges or Privileges means the authorization granted by the Board of Directors to a Practitioner or AHP to provide specific patient care services at the Hospital within defined limits.

Clinical Service means a group of Appointees who share a specialized commonality or clinical perspective and who have been established and/or recognized by the Medical Executive Committee.

Clinical Service Chief means the individual selected by members of a Clinical Service to manage the affairs of the Clinical Service.

Dentist means an individual who has received a doctor of dental medicine or doctor of dental surgery degree and is currently licensed to practice Dentistry in the state of Ohio and whose practice is in the area of oral and maxillofacial surgery or the area of general Dentistry or a specialty thereof.

Department means a department of the Hospital. The term does not refer to a clinical division of the Medical Staff as the Medical Staff is divided into clinical services.

Emergency Department Call means a process whereby patients who do not have an attending Practitioner may be provided medical care services by a Practitioner scheduled to be available to provide that service and who is capable of admitting and providing the level of medical care required during a patient's hospitalization.

Ex Officio means appointment to a body by virtue of an office or position held. *Ex Officio* members shall not be counted for purposes of determining a quorum nor shall they have voting rights unless a specific provision provides otherwise.

Federal Health Program means Medicare, Medicaid, TriCare, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

Good Standing means absence of disciplinary actions.

Hospital means Kettering Medical Center.

Joint Conference means an ad hoc committee of officers of the Medical Staff and officers of the Board of Directors.

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

Medical Staff means all allopathic Physicians, osteopathic Physicians, Dentists (including oral maxillofacial surgeons), Podiatrists, and Psychologists who have obtained appointment status at the Hospital with such responsibilities, prerogatives, and privileges as defined in the category to which each has been appointed.

Medical Staff Bylaws or Bylaws means the articles and amendments that constitute the basic governing documents of the Medical Staff.

Oral Surgeon or Maxillofacial Surgeon means a practitioner who has successfully completed an accredited post-graduate/residency program in oral/maxillofacial surgery.

Organized Medical Staff means Active Staff

Patient Encounter means, in the inpatient setting, an inpatient admission, consultation (resulting in not less than a progress note), or surgery/invasive procedure; and in the outpatient setting, surgery/invasive procedure.

Physician means an individual who has received a doctor of allopathy degree or doctor of osteopathy degree and is currently licensed to practice medicine in the state of Ohio.

Podiatrist means an individual who has received a doctor of podiatric medicine (D.P.M.) degree who is fully licensed to practice podiatry in the State of Ohio.

Practitioner means, unless otherwise expressly provided, a Physician, Dentist, Podiatrist, or Psychologist.

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

Professional Liability Insurance means insurance coverage acceptable to the Board as the Board may determine from time to time by an insurance company licensed in the United States or having coverage by a company who has an underwriting agreement with a licensed U.S. insurance company to assure adequate reserves for payment of claims.

Psychologist means an individual with a doctoral degree in psychology or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who is currently licensed to practice psychology.

Rules & Regulations means the compendium of rules and regulations promulgated by the Medical Staff as approved by the Board to govern specific administrative and patient care issues that arise at the Hospital.

Special Notice means written notice (a) sent by certified mail, return receipt requested; or (b) delivered personally with the affected individual either signing as proof of receipt or other written documentation from the individual delivering the notice as to why signature was not obtained.

Telemedicine means the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider, and for the purpose of improving patient care.

Vice President Medical Affairs means the individual appointed by the Board, upon recommendation by the medical staff, to act in this capacity.

Words used in these Bylaws shall be read as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

Whenever an individual is authorized to perform a duty by virtue of his or her position, then the term shall also include the individual's designee.

ARTICLE 1. PREAMBLE & PURPOSES

These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between Appointees and the Hospital, and are subject to the corporate authority of the Board in those matters where the Board has ultimate legal responsibility. These Bylaws are not intended to be and are not to be construed as a contract.

The purposes of this Medical Staff are to:

(a) Provide a mechanism for accountability to the Board through defined organizational components and positions for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff or otherwise granted Privileges at the Hospital, to the end that patient care provided at the Hospital is maintained at that level of quality and efficiency which is commensurate with, or superior to, generally recognized standards of care.

(b) To serve as the collegial body through which Practitioners may obtain Prerogatives and Privileges at the Hospital, fulfill their obligations of Medical Staff appointment, and practice in an environment that promotes quality and efficient patient care.

(c) To provide on behalf of the Hospital an appropriate educational setting and to maintain high scientific and educational standards for continuing medical education programs for Appointees of the Medical Staff.

(d) To provide an orderly and systematic means by which Appointees can give input to the Board and President/CEO on medico-administrative problems and on the Hospital's policy-making and planning processes.

(e) To initiate, maintain, and enforce the Medical Staff Bylaws, other related medical staff governance documents and policies for self-governing of the Medical Staff.

ARTICLE 2. MEDICAL STAFF APPOINTMENT

SECTION 2.1. NATURE OF MEDICAL STAFF APPOINTMENT

Appointment to the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

SECTION 2.2. QUALIFICATIONS FOR APPOINTMENT

2.2.1. In General. Only Physicians, Dentists, Psychologists, or Podiatrists, holding a license to practice in the State of Ohio; who can document their background, experience, training, judgment, individual character, and demonstrated current competence; ability to exercise the privileges requested with or without a reasonable accommodation; adherence to the ethics of their profession; and ability to work cooperatively with others with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given a high quality of health care, shall be qualified for appointment to the Medical Staff. The Medical Staff reserves the right to rely on the criminal records check (CRC) conducted by the State Medical Board of Ohio in connection with a practitioner's new license or license restoration; or to conduct its own CRC at any time. A CRC must not evidence convictions of certain offenses that would act to disqualify an applicant from consideration for appointment or reappointment to the Medical Staff. No practitioner, including those in a medico-administrative position by virtue of a contract with the Hospital, shall treat or otherwise provide medical care to a patient in the Hospital unless the practitioner is an Appointee and has been granted privileges to do so. No practitioner shall be entitled to appointment to the Medical Staff or to exercise privileges in the Hospital merely by virtue of the fact that the practitioner is duly licensed to practice medicine, dentistry, psychology, or podiatry in this or any other state; or soley based upon certification, fellowship or membership in a specialty body or society; or that the practitioner had in the past, or now has, such privileges at another hospital.

2.2.2. Eligibility.

(a) Proof of professional liability insurance consistent with the amount specified by the Board.

(b) Proof of current licensure or registration and verification of not currently being excluded for cause by the secretary of Health and Human Services from participation in any Federal Health Program as a provider, pursuant to Sec. 1128 (42 U.S.C. 1320a-7).

(c) For appointment of a Physician or Podiatrist to the active or courtesy Medical Staff category, documentation of experience and training, including completion of a residency approved by Accreditation Council for Graduate Medical Education (ACGME"), American Board of Medical Specialties **("**ABMS**")**, or American Osteopathic Association ("AOA"). Physicians and Podiatrists who have been on the Medical Staff prior to January 1, 1996 are not obligated to meet this requirement.

(d) For appointment of a Physician or Podiatrist to the active or courtesy Medical Staff category, applicants must be within six (6) years of completing their residency program or possess current board certification as specified by the ABMS, AOA, American Board of Oral & Maxillofacial Surgery ("ABOMS"), American Board of Podiatric Surgery ("ABPS"), or the American Board of Podiatric Primary Medicine and Orthopedics (ABPPMO). Those applicants (excluding Dentists and Psychologists) who do not possess current board certification at initial appointment must obtain board certification within six (6) years of completing his/her residency program to maintain appointment to the Medical Staff and Privileges. Physicians and Podiatrists who have been on the Medical Staff since January 1, 1996, or who are otherwise excused by the Board for good cause shown, are not obligated to meet this requirement.

(e) All applicants must evidence good moral character as evidenced, in part, by the absence of convictions for certain criminal offenses as determined by a criminal records check performed either by the State Medical Board of Ohio or via the Medical Staff Services Department.

SECTION 2.3. NONDISCRIMINATION

Neither the Hospital nor its Medical Staff will discriminate in granting Medical Staff appointment or privileges on the basis of disability, or any discriminatory basis recognized by current law.

SECTION 2.4. CONDITIONS AND DURATION OF APPOINTMENT

2.4.1. Appointment and Reappointment. Initial appointment and reappointment to the Medical Staff shall be made by the Board of Directors. The Board shall act on appointment and reappointment only after there has been a recommendation from the Medical Executive Committee or as otherwise provided in these Bylaws. All individuals and committees required to act on an application for Medical Staff appointment must do so in a timely manner and, except for good cause, each application should be processed within one hundred twenty (120) days from receipt of an application determined to be complete.

2.4.2. Term. Appointments to the Medical Staff and grants of privileges will be for no more than twenty-four (24) calendar months. Appointments and/or grants of privileges for a period of less than twenty-four (24) calendar months shall not be deemed adverse.

2.4.3. Prerogatives. Appointment to the Medical Staff shall confer on the Appointee only prerogatives as have been granted in accordance with these Bylaws.

SECTION 2.5. MEDICAL STAFF DUES

2.5.1. Dues. Annual Medical Staff dues shall be governed by the most recent action recommended by the Medical Executive Committee and adopted at a regular or special Medical Staff meeting. The Vice Chief shall notify each Appointee, in writing, of any contemplated change in Medical Staff dues at least twenty-one (21) days before the meeting at which voting on such proposed change is to take place.

2.5.2. Exceptions. Consulting Peer Review, Retired, and Honorary Medical Staff Appointees are not required to pay dues.

2.5.3. Payment. Dues, if required, shall be due and payable within thirty (30) days of written request. A failure to pay Medical Staff dues within the required time frame shall be construed as a voluntary resignation from the Medical Staff.

SECTION 2.6. ETHICAL REQUIREMENTS

A practitioner who accepts appointment to the Medical Staff and/or privileges agrees to act in an ethical, professional, and courteous manner consistent with the Hospital's code of ethics as well as any applicable ethics of the practitioner's practice and related Hospital and Medical Staff Bylaw provisions and policies.

SECTION 2.7. RESPONSIBILITIES OF APPOINTMENT & EXERCISE OF PRIVILEGES

Each Appointee may independently direct the care of his/her patients within the scope of the Appointee's privileges subject to the Medical Staff Bylaws, Organization Manual, Credentials Manual, and any other applicable policy. Each Appointee is subject to review as a part of the Hospital's performance improvement activities. No Appointee is responsible for the actions of other Appointees or AHPs unless the individual is practicing in collaboration with or under the supervision of such Appointee. No Appointee is responsible for the actions of Hospital employees unless the Appointee contracts, in writing, to undertake such responsibility.

ARTICLE 3.
CATEGORIES OF THE MEDICAL STAFF

SECTION 3.1. ACTIVE MEDICAL STAFF

Appointment to the active Medical Staff will be provisional for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and as approved by the Board. Active Appointees consist of those Physicians, Dentists, Podiatrists, and Psychologists who engage in significant clinical practice at the Hospital. Hospital-based Practitioners (including but not limited to pathologists, anesthesiologists, radiologists, radiation oncologists, and emergency medicine Physicians) who are either employed by the Hospital or have exclusive contracts for the provision of patient care at the Hospital will be assigned to the active Medical Staff.

3.1.1. Qualifications. Appointees to this category must:

(a) Meet all qualifications for Medical Staff appointment as set forth in Article II, Section 2.

(b) Actively participate in Medical Staff activities and responsibilities, such as committee and Clinical Service assignments.

(c) Provide evidence of clinical performance at all other hospitals in which they practice in such form as the Hospital may reasonably request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

3.1.2. Prerogatives. Appointees to this category may:

(a) Admit and consult on patients without limitation, except as otherwise provided in the Medical Staff Rules & Regulations or by specific privilege restriction.

(b) Attend meetings of the Medical Staff and of the Clinical Service of which the Practitioner is member as well as Medical Staff or Hospital education programs.

(c) Vote on all matters presented at general and special meetings of the Medical Staff, and of the Clinical Service and committee(s) of which the practitioner is a member.

(d) Hold office and sit on or be the chair of any committee, unless otherwise specified in these Bylaws.

(e) Participate in Hospital and Medical Staff education programs as appropriate.

3.1.3. Responsibilities. Appointees to this category must:

(a) Contribute to the organization and administrative affairs of the Medical Staff.

(b) Actively participate in recognized functions of Medical Staff appointment, including performance improvement, peer review, and other monitoring activities; proctor Appointees during their provisional period or when new privileges are granted; and discharge other Medical Staff functions as may be required from time to time.

(c) Participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration or Board. Medical Staff members with unique or scarce expertise are expected to collegially assist other medical staff members when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome.

(d) Attend applicable meetings.

(e) Serve on Medical Staff committees, as assigned.

(f) Faithfully perform the duties of any office or position to which elected or appointed.

(g) Must pay all application fees, dues, and assessments that may be enacted by the Medical Executive Committee.

SECTION 3.2. COURTESY MEDICAL STAFF

Appointment to the Courtesy Medical Staff will be provisional for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and approved by the Board.

3.2.1. Qualifications. Appointees to this category must:

(a) Meet all qualifications for Medical Staff appointment as set forth Article II, Section 2.

(b) Have not more than fifty (50) Patient Encounters in a consecutive twenty-four (24) month period (not including referrals to the Hospital's diagnostic facilities, access to which is unlimited). Appointees that have more than fifty (50) Patient Encounters or anticipate having more than fifty (50) Patient Encounters in an appointment period will automatically be transferred to the Active Medical Staff.

(c) Provide evidence of clinical performance at all other hospitals in which they practice, in such form as the Hospital may reasonably request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

3.2.2. Prerogatives. Appointees to this category:

(a) May admit, treat, and consult on patients without limitation, based on applicable Privileges, except as otherwise provided in the Medical Staff Rules & Regulations, or by specific Privilege restriction.

(b) May attend Medical Staff meetings (without vote).

(c) May attend applicable Clinical Service meetings (without vote).

(d) May be invited to serve on committees (with vote).

(e) May not hold office or serve as a Clinical Service Chief or committee chair.

(f) Is excused from the care of unassigned patients and from Emergency Department Call (unless there is a determination by the applicable Clinical Service Chief, Medical Executive Committee, Administration and/or the Board that courtesy Medical Staff Appointees of a particular Clinical Service must participate in these responsibilities).

(g) Must participate in performance improvement, monitoring, and peer review activities, including responding fully and timely to any inquiries regarding the care of patients.

(h) Must pay all application fees, dues and assessments, which may be enacted upon by the Medical Executive Committee.

3.2.3. Responsibilities. Appointees to this category have the same responsibilities as active Medical Staff, if requested.

SECTION 3.3. AFFILIATE MEDICAL STAFF

3.3.1 Membership Only

3.3.1.1 Qualifications. Appointees to this category shall consist of those practitioners who desire to be affiliated with the Hospital, but who do not intend to provide patient care at the Hospital. The primary purpose of the Affiliate Medical Staff - Membership is to promote professional and educational opportunities, including continuing medical education endeavors, and to allow such practitioners to refer patients to other Appointees for admission, evaluation, and/or care and treatment. Appointees to this category must meet the general qualifications for appointment but shall not be required to maintain professional liability insurance or to otherwise provide documentation establishing current clinical competence.

3.3.1.2. Prerogatives. Appointees to this category:

(a) May attend meetings of the Medical Staff and appropriate Clinical Service (without vote).

(b) Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).

(c) May attend educational programs of the Medical Staff.

(d) May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.

(e) May visit their patients when hospitalized and review their medical records (provided the patient consents), but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to patients.

(f) May refer patients to the Hospital's diagnostic and treatment facilities.

(g) May not be granted privileges and may not admit or treat patients at the Hospital.

3.3.1.3. Responsibilities. Appointees to this category:

(a) Must pay all application fees, dues and assessments that are enacted by the Medical Executive Committee.

3.3.2 Clinical Privileges Only

3.3.2.1 Qualifications. Appointees to this category shall consist of those practitioners who desire to have clinical privileges with the Hospital, but who do not desire medical staff membership. The purpose of the Affiliate Medical Staff – Clinical Privileges is limited to those practitioners who desire to provide health care services to patients in either a locum tenens and/or proctoring capacity or residents who desire an opportunity to obtain privileges to moonlight in the Emergency Services Department.

(a) Appointees to this category must meet all qualifications for Medical Staff appointment as set forth in Article II, Section 2. with the exception of residents who will not have yet fulfilled the criteria in Article II, Section 2.2.2 (c) and (d).

(b) Provide evidence of clinical performance at all other hospitals and healthcare organizations in which they practice, in such form as the Hospital may reasonable request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

3.3.2.2 Prerogatives. Appointees to this category:

(a) Admit and consult on patients without limitation, except as otherwise provided in the Medical Staff Rules & Regulations or by specific privilege restriction.

(b) Participate in Hospital and Medical Staff education programs as appropriate.

(c) Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).

(d) May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.

3.3.2.3. Responsibilities. Appointees to this category:

(a) Participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration or Board. Medical Staff members with unique or scarce expertise are expected to collegially assist other medical staff members when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome.

(b) Attend applicable meetings.

(c) Must pay all application fees, dues and assessments, which may be enacted upon by the Medical Executive Committee.

SECTION 3.4. CONSULTING PEER REVIEW MEDICAL STAFF

3.4.1. Qualifications. A consulting peer review Medical Staff Appointee must meet the following criteria:

(a) Practice either locally or in another city and state in which he or she has a valid license to practice.

(b) Possess specialized skills needed at the Hospital for a specific project or on an occasional basis when requested by Hospital administration, the Board, or a Medical Staff committee.

(c) Demonstrate active participation on the active medical staff at another Hospital requiring performance improvement/quality assessment activities similar to those of this Hospital unless the nature of the services being requested do not require that the individual have such experience.

3.4.2. Prerogatives. Appointees to this category:

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

(b) May be requested to attend Medical Staff meetings or attend certain committee or Clinical Service meetings.

(c) May not be granted Privileges and may not admit or treat patients to the Hospital.

(d) May not be permitted to hold office or to vote.

(e) Must execute a HIPAA compliant Business Associate Agreement.

3.4.3. Responsibilities. A consulting peer review Medical Staff Appointee shall perform such duties as are requested and which he or she agrees to perform.

SECTION 3.5. PROBATIONARY MEDICAL STAFF STATUS

The Medical Executive Committee may impose a probationary Medical Staff status (different than the provisional period required for the first year of active and courtesy Medical Staff categories) for corrective action issues related to privileges and/or for non-clinical reasons. The Medical Executive Committee shall define the time period (not longer than one (1) year) and the expected requirements of a successful probationary period. If the Appointee does not successfully fulfill the requirements of the probationary period as determined by the Medical Executive Committee, the Medical Executive Committee may initiate corrective action in accordance with these Bylaws.

SECTION 3.6. RETIRED MEDICAL STAFF

3.6.1. Qualifications. The retired Medical Staff shall consist of practitioners who have retired from active practice and who, at the time of their retirement, were Appointees in good standing to the Medical Staff, and who continue to adhere to appropriate professional and ethical standards. They shall have no privileges and shall be exempt from all Medical Staff qualifications and requirements. Requests for appointment to the Retired Staff will be directed to the MEC and shall be a lifetime appointment.

3.6.2. Prerogatives. Appointees to this category:

(a) Shall not be eligible to have Privileges, to vote, to hold office, or to serve on standing Medical Staff Committees.

(b) May attend educational programs at the Hospital.

(c) May be requested to sit on an *ad hoc* committee of the Medical Staff. If so appointed, they may participate on such committee with vote.

3.6.3. Responsibilities. Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee's responsibilities.

SECTION 3.7. THE *HONORARY* MEDICAL STAFF

3.7.1. Qualifications. The honorary Medical Staff shall consist of those previous Appointees who have retired from active practice, have served on the active Medical Staff for a minimum of ten (10) years, and have either contributed in an outstanding manner through leadership positions at the Hospital or through significant service to the community. They may be granted honorary Medical Staff status upon

the recommendation of the Chief of Staff, supported by the Medical Executive Committee, with the approval of the Board. They shall have no privileges and shall be exempt from all Medical Staff qualifications and requirements. Requests for appointment to the honorary Medical Staff should be directed to the MEC for recommendation to the Board.

3.7.2. Prerogatives. Appointees to this category:

(a) Shall not be eligible to have Privileges, to vote, to hold office, or to serve on standing Medical Staff Committees.

(b) May attend educational programs at the Hospital.

(c) May be requested to sit on an *ad hoc* committee of the Medical Staff. If so appointed, they may participate on such committee with vote.

3.7.3. Responsibilities. Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee's responsibilities.

ARTICLE 4.
OFFICERS

SECTION 4.1. OFFICERS OF THE MEDICAL STAFF

4.1.1. The officers of the Medical Staff shall be:

- Chief of Staff
- Vice Chief
- Vice Chief Sycamore Medical Center
- Vice Chief Medical Staff Credentials Program

SECTION 4.2. QUALIFICATION OF OFFICERS

Officers must:

(a) Be Appointees to the active Medical Staff.
(b) Have been on the active Medical Staff for at least the previous five (5) consecutive years.
(c) Be in Good Standing at the time of nomination and election.
(d) Remain active Appointees in Good Standing during their terms of office.
(e) Be board certified as specified by the ABMS, AOA, ABOMS, ABPS or ABPPMO.

Officers may not simultaneously hold leadership positions at another hospital.

SECTION 4.3. ELECTION OF OFFICERS

4.3.1. General. Officers shall be elected bi-annually at a meeting of the Medical Staff. Only active Appointees shall be eligible to vote. Upon completion of the Chief of Staff term, the Vice Chief automatically becomes Chief of staff.

4.3.2. Nominating Committee. The nominating committee shall be appointed by the MEC and shall consist of the Chief of Staff, the Vice Chief, two (2) other members of the Medical Executive Committee, and three (3) other active Appointees who are not then members of the MEC. The nominating committee will present a panel of candidates to the MEC for approval no later than two (2) MEC meetings prior to the meeting at which the election shall be held. When approved, the names of the nominees will be distributed to all active Appointees.

4.3.3. Additional Nominations. Within thirty (30) days of distribution, additional nominations may also be made by petition signed by either ten percent (10%) of active Appointees or fifty (50) active Appointees, whichever is less. Such petition must be submitted to the Chief of Staff who shall then include these nominations on the distributed ballot.

4.3.4. Ballots. Ballots will be mailed to active Appointees no later than thirty (30) days prior to the annual meeting. Ballots must be received by the Medical Staff Office no later than seven (7) days prior to the meeting at which the election is to be held.

4.3.5. Disclosure of Conflicts. All nominees for election or appointment to Medical Staff offices at the time of nomination shall disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Such disclosures will be provided with the ballot.

SECTION 4.4. TERM OF OFFICE

All elected officers will serve a term of two (2) years. Officers shall take office on the first day of the calendar year.

SECTION 4.5. VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except the office of the Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of the Chief of Staff, the Vice Chief shall serve the remainder of the term, and then may serve his or her own term as Chief of Staff.

SECTION 4.6. DUTIES OF OFFICERS

4.6.1. Chief of Staff. The purpose of this position is to provide overall leadership and guidance to the Medical Staff. Additionally, it is essential that the Chief of Staff will promote effective communications among the Medical Staff, Medical Executive Committee, Administration, and the Board. The individual occupying this position will serve as the Chief Medical Officer of the institution and will be responsible for bylaws implementation, Medical Staff involvement in securing and maintaining TJC accreditation, providing information to the Board concerning matters that pertain to the care and treatment of patients and generally facilitating positive relationships among administration, the Medical Staff and other support services of the institution.

4.6.2. Chief-Elect. The purpose of this position is to provide continuity in leadership during times when the Chief of Staff is absent or otherwise unable to perform his/her assigned functions. The Chief-Elect will be expected to remain knowledgeable about all Medical Staff issues of current Medical Staff interest. At the conclusion of the term of the Chief of Staff, the Chief-Elect will succeed as Chief of Staff.

4.6.3. Vice Chief, Sycamore Medical Center. To provide leadership to the Medical Staff who practice primarily at Sycamore Medical Center (SMC) and promote effective communication between those physicians, hospital administration and other members of the Medical Staff leadership.

4.6.4. Vice Chief, Medical Staff Credentials Program. To provide oversight for the Credentials Program of KMC and direction to the hospital Board of Directors in credentialing members of the Medical Staff. To maintain compliance with the credentialing policies of the hospital, TJC and applicable law.

Please refer to the Organization Manual for details as to the position requirements, accountabilities and functions.

SECTION 4.7. REMOVAL FROM OFFICE

The Medical Staff may remove any officer by petition signed by twenty-five percent (25%) of the active Appointees approved by a subsequent two-third (2/3) vote by ballot of the active Appointees. Automatic removal shall be for failure to conduct those responsibilities assigned within these bylaws or in other manuals; failure to comply with policies and procedures of the medical staff; conduct or statement damaging to the hospital, its goals, or its programs; or an automatic or summary suspension of clinical privileges that lasts for more than 30 days. The Board will determine the existence of such failures after it consults with the MEC.

ARTICLE 5.
MEDICAL STAFF STRUCTURE

SECTION 5.1. ORGANIZATION OF THE MEDICAL STAFF

5.1.1. Medical Executive Committee. The Medical Staff shall be non-departmentalized. The MEC shall be responsible for the promotion of quality of care at the Hospital and reviewing the professional performance of Practitioners and AHPs rendering care at the Hospital. The MEC shall constitute the governing body of the Medical Staff as described in these Bylaws.

5.1.2. Clinical Services. The following groups of Practitioners have been organized into Clinical Services:

- Anesthesiology
- Emergency Medicine
- Family Medicine
- Medical Imaging
- Internal Medicine
- Obstetrics/Gynecology
- Orthopedics
- Pathology
- Pediatrics
- Surgery

Other groups may elect to organize in the future with the approval of the Medical Executive Committee.

5.1.3. Organization. Organized Clinical Services must select a Clinical Service Chief and an assistant Clinical Service Chief, each to serve for a two (2) year term (which may be repeated for an unlimited number of terms). Should the Clinical Service be unable to elect a Chief or Assistant Chief, then the MEC will appoint an appointee to fulfill these positions. The description of these positions is set forth in the Organization Manual. The MEC may remove any Clinical Service Chief or assistant Clinical Service Chief by a two-third (2/3rd) vote of the MEC. The vote will be called after twenty-one (21) days advance notice. Removal shall be for failure to conduct those responsibilities assigned within these Bylaws or other policies and procedures of the Medical Staff.

5.1.4 Election Process

(a) Clinical Service Chief will be elected by majority vote of the active members of the clinical service participating in the vote.

(b) Six months prior to completion of the term of the Clinical Service Chief, the current clinical service chief will put forth a communication (i.e. memo, email, agenda item, etc.) calling for nominations.

(c) 30 days prior to the next scheduled clinical service meeting, a ballot will be distributed to all active appointees within the clinical service for vote.

(d) The results of the election will be announced at the next clinical service meeting.

(e) Should the clinical service be unable to elect a Chief and Assistant Chief the MEC will appoint an appointee to fulfill these positions.

SECTION 5.2. MEDICAL STAFF CLINICAL SERVICE CHIEFS

5.2.1. Qualifications. Individuals occupying this position must:

- Be an active Appointee.
- Have been an active Appointee for at least the prior three (3) years.
- Board Certified within respective specialty.

5.2.2. Responsibilities. A Clinical Service Chief has the following responsibilities:

(a) Overseeing all clinically related activities of the Clinical Service, including the development of applicable sections within the clinical service.

(b) Making recommendations to the Chief of Staff, as requested, on appointments of Clinical Service members to committees.

(c) Recommending to the Medical Staff professional criteria for privileges that are relevant to the quality care provided in the Clinical Service.

(d) Reviewing applications for initial appointment and reappointment as well as requested privileges for each practitioner and AHP assigned to the Clinical Service and for providing opinions to the Credentials Committee as to what action should be taken on the application.

(e) Integrating the Clinical Service into the primary function of the Hospital.

(f) Providing orientation and monitoring of the continuing education of all Practitioners and AHPs in the Clinical Service.

(g) Coordinating and integrating services within the Clinical Service with other Clinical Services.

(h) Overseeing all administratively related activities of the Clinical Service, unless otherwise provided for by the Hospital or the Medical Staff.

(i) In conjunction with the Chief of Staff, accessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Clinical Service or the Hospital.

(j) In conjunction with the Chief of Staff, developing and implementing policies and procedures that guide and support the provision of care, treatment and services.

(k) In conjunction with the Chief of Staff, making recommendations for a sufficient number of qualified and competent persons to provide care, treatment or services.

(l) In conjunction with the Chief of Staff, determining qualifications and competence of Hospital Department and Clinical Service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

(m) In conjunction with the Chief of Staff, making recommendations for space, capital equipment, personnel, and other resources needed by the Clinical Service.

(n) In conjunction with the Chief of Staff, providing continuing surveillance of the professional performance of all practitioners and AHPs in the Clinical Service.

(o) In conjunction with the Chief of Staff, providing continuous assessment and improvement of the quality of care, treatment and services.

(p) In conjunction with the Chief of Staff, assuring the maintenance of quality control programs, as appropriate.

SECTION 5.3. ASSISTANT CLINICAL SERVICE CHIEF

5.3.1. Qualifications. Individuals occupying this position must:

- Be an active Appointee.
- Have been an active Appointee for at least the past three (3) years.
- Board Certification within respective specialty.

5.3.2. Responsibilities. The Assistant Clinical Service Chief is responsible for (a) working with the Clinical Service Chief, for all clinically related activities of the Clinical Service; and (b) fulfilling the duties and responsibilities of the Clinical Service Chief in his/her absence.

SECTION 5.4. REMOVAL OF CLINICAL SERVICE CHIEF/ASSISTANT CHIEF

Clinical service chiefs/assistant chiefs may be removed from their position by the MEC upon receipt of a recommendation of two-thirds (2/3rd) of the active Appointees of the clinical service, or, in the absence of such recommendation, the MEC may remove a clinical service chief on its own by a two-thirds (2/3rd) vote, of members present, if any of the following occurs:

- The chief/assistant chief ceases to be an active member in good standing of the medical staff.

- The chief/assistant chief suffers an involuntary loss or significant limitation of practice privileges.

- The chief/assistant chief fails, in the opinion of the MEC, to demonstrate to the satisfaction of the MEC or Board that he or she is effectively carrying out the responsibilities of the position.

If removal of the chief is required, then the assistant chief automatically assumes the responsibilities of the Chief until a new election can be held or an appointment made by the MEC.

ARTICLE 6.
MEDICAL EXECUTIVE COMMITTEE

6.1.1. Composition. The Medical Executive Committee will include the Chief of Staff, Vice Chief, Vice Chief Sycamore Medical Center, immediate past Chief of Staff, Director of Medical Staff Credentials Program, and representatives from each Clinical Service (selected by the members of each Clinical Service for a two year term). The President/CEO, Vice President Medical Affairs, Vice President Patient Care (CNO), Medical Staff representative to the Organized Medical Staff Section of the American

Medical Association, Director of Medical Education and a member representing the Board of Directors will be members *Ex Officio*. The Chief of Staff of the Medical Staff serves as chair of the committee.

6.1.2. Duties. The duties of the Medical Executive Committee shall be to:

(a) Represent and to act on behalf of the Medical Staff, in the intervals between general Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

(b) Receive and act upon reports and recommendations from Medical Staff committees, joint Hospital/Medical Staff committees, Clinical Services, and assigned activities groups.

(c) Coordinate, provide leadership, and implement the professional, clinical, performance improvement (including customer satisfaction and patient safety), and organization activities and policies of the Medical Staff including peer review, which helps to create and maintain a culture of safety and quality throughout the hospital (LD 2.20 & 3.10 2009).

(d) Act as liaison between the Medical Staff and the Chief of Staff.

(e) Recommend action to the Chief of Staff on matters of a medico-administrative nature and to recommend the Medical Staff organization structure to the Board of Directors.

(f) Make recommendations on Hospital management matters to the Board of Directors through its Professional Practice Committee.

(g) Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation and licensure status of the Hospital.

(h) Fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to patients in the Hospital.

(i) Design a mechanism to ensure that the same level of appropriate quality of patient care is provided by all individuals with privileges, within the Clinical Services, across Clinical Services, and between Appointees and non-Appointees who have privileges during the patient's entire stay at the Hospital.

(j) Oversee the quality of patient care, treatment, and services provided by Practitioners and AHPs.

(k) Review the qualifications, credentials, performance, professional competence, and character of applicants, Appointees, practitioners, and AHPs, and to make recommendations to the Board of Directors regarding, appointment, reappointment, termination, assignments to Clinical Services, privileges, and corrective action.

(l) Request evaluations of a practitioner's or AHP's privileges through the Medical Staff process in instances where there is doubt as to an applicant's, Appointee's, or AHP's ability to perform the privileges requested.

(m) Take all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of practitioners and AHPs with privileges.

(n) Conduct such other functions as are necessary for the effective operation of the Medical Staff.

(o) Direct mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's appointment and/or privileges.

(p) Establish mechanisms to provide effective communications among the Medical Staff, Hospital administration, Board, and all levels of governance involved in policy decisions affecting patient care services in the Hospital.

(q) Establish mechanisms by which house staff are supervised by Appointees in carrying out their patient care responsibilities.

(r) Report at each general Medical Staff meeting.

(s) Access and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital.

(t) Make recommendations for the position of Vice President Medical Affairs to the Board of Directors from among those nominees.

6.1.3. Meetings. The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

6.1.4. Any active Appointee has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve an issue by working with his/her Clinical Service Chief, the Appointee may, upon presentation of at least two (2) week written notice, meet with the Medical Executive Committee at its next regularly scheduled meeting to discuss any unresolved issues.

ARTICLE 7.
MEDICAL STAFF FUNCTIONS

Provisions shall be made in these Bylaws, or by resolution of the Medical Executive Committee approved by the Board, either through assignment to Medical Staff committees, to Medical Staff officers, or to interdisciplinary Hospital committees, for the effective performance of the Medical Staff functions specified in this Section and described in other related medical staff governance documents, and of such other Medical Staff functions as the Medical Executive Committee or the Board shall reasonably require.

SECTION 7.1. FUNCTIONS

(a) Monitoring and evaluating the care provided in and developing clinical policy for special care areas, such as intensive or coronary care units and all Hospital-based services.

(b) Conducting or coordinating quality and appropriateness and improvement activities, including invasive and non-invasive procedures, blood usage, drug usage reviews, medical record and other reviews.

(c) Conducting or coordinating utilization review activities.

(d) Conducting or coordinating credentials investigations regarding Medical Staff appointment and grants of Privileges and specified services.

(e) Providing continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs and supervise the Hospital's professional library services.

(f) Developing and maintaining surveillance over drug utilization policies and practices.

(g) Investigating and controlling nosocomial infections and monitoring the Hospital's infection control program.

(h) Directing Medical Staff organization activities, including review and revision of Medical Staff Bylaws, Medical Staff officer and committee nominations, acting as liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation and licensure.

(i) Coordinating the care, including patient and family education, provided by Appointees with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services.

(j) Engaging in other functions reasonably requested by the Medical Executive Committee and Board.

SECTION 7.2. HISTORY AND PHYSICAL

A current complete history and physical (H & P) examination consists of the following required elements: chief complaint, history of present illness, past history, social history, family history, review of systems, relevant physical examination, impression and plan of care. For those patients for which a surgery/procedure is to be performed, the H & P must include indications for surgery as documented by the operating surgeon. A complete H & P examination shall be placed on the patient's chart or dictated within twenty-four (24) hours after admission or as otherwise required by current state law and/or accreditation standards.

The H & P examination records are the responsibility of the attending physician and properly documented by signature, date and time. Medical student H & P examination will not be part of the medical record unless they are written and signed by a supervising resident or attending physician. Medical student dictation will not be transcribed by Kettering Medical Center.

The H & P must be completed and documented by one of the following practitioners:

- Doctor of medicine or osteopathy
- Doctor of podiatric medicine (in accordance with Ohio State law and as indicated in the Credentials Manual)
- Doctor of dental surgery or of dental medicine (in accordance with Ohio State law and as indicated in the Credentials Manual)
- Physician Assistants
- Nurse Practitioners

Should the H & P be provided by a non-credentialed practitioner (i.e. patient's primary care practitioner), then an update must be completed and documented by a licensed practitioner who is appropriately credentialed and privileged in accordance with medical staff bylaws and other related manuals.

<u>Medical H & P</u>
A current complete medical H & P is one completed within (thirty) 30 days prior to admission and updated within twenty-four (24) hours after admission.

When the admission H & P has been dictated but not yet transcribed and on the chart, an admission note which adequately describes the patient's condition, diagnoses and plan of care shall be placed on the

chart within 24 hours of admission when the H & P is not on the chart.

Surgical H & P
A current complete surgical H & P is one completed within (thirty) 30 days prior to the surgery/procedure and has been updated by the operating surgeon within 24 hours prior to the surgery/procedure. Update to indicate the following: H & P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H & P was completed or any changes in the patient's condition must be documented in the update note and placed in the patient's medical record within 24 hours of admission, but prior to surgery/procedure requiring anesthesia.

If the practitioner finds that the H & P done before admission is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H & P, examining the patient, and completing the update may disregard the existing H & P and conduct and document in the medical record a new H & P within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

Ambulatory/Outpatient H & P
Ambulatory patients who are undergoing procedures not requiring procedural sedation or anesthesia, except local anesthesia, do not require a complete H & P on the chart. Only a pertinent note concerning the nature of the disease process leading to the procedure and the intended procedure is necessary in these cases. Other pertinent positive findings, such as drug allergies and serious pre-existing disease entities should also be noted.

See Organization Manual, Rules and Regulations for additional information.

SECTION 7.3. CREDENTIALING, PRIVILEGING, AND APPOINTMENT

Once an application is deemed complete, the credentialing, privileging and appointment are recommended by the appropriate clinical services, reviewed and approved by the Credentials Committee, Medical Executive Committee for final action by the Board, including medical staff membership. Time frame to complete this process 120 days. Temporary privileges for a new applicant, new procedure, or to fulfill an important patient care need may be requested as outlined in the Credentials Manual.

In the event of a disaster, volunteer licensed independent practitioners, may be granted "disaster" privileges as outlined in the Credentials Manual and in accordance with applicable hospital policies and procedures.

A full description of the procedural details is outlined in the Credentials Manual, which is a medical staff governance document, approved and amended through the Medical Staff process and the Board.

See Credentials Manual for additional information

ARTICLE 8.
CORRECTIVE ACTION

SECTION 8.1. BEHAVIOR LEADING TO INITIATION OF INVESTIGATION

8.1.1. Informal Investigation. Informal investigation may be initiated whenever a practitioner engages in, makes or exhibits acts, statements, demeanor or professional conduct either within or outside the Hospital, and the same is, or is reasonably likely to be detrimental to the quality of patient care or safety, disruptive to the Hospital's operations, or an impairment to the community's confidence in the Hospital.

8.1.2. Automatic Suspension. Automatic suspension of a practitioner's appointment and/or privileges shall be triggered whenever there is revocation, suspension, restriction or probation of the practitioner's state license or DEA number when applicable; whenever there is failure to satisfy a special appearance requirement; whenever the practitioner fails to maintain malpractice insurance, when a criminal records check evidences conviction of certain offenses and whenever a practitioner's medical records are not completed in a timely manner.

8.1.3. Summary Suspension. Summary suspension of a practitioner's appointment and/or privileges shall be initiated whenever a practitioner's conduct requires that immediate action be taken to prevent immediate danger to life, or substantial likelihood of injury to patients, employees, or other persons present in the Hospital.

SECTION 8.2. INTERVIEWS PRIOR TO FORMAL INVESTIGATION AND CORRECTIVE ACTION

When considering initiating investigation or corrective action, the initiating individual or committee may, but is not required to, interview the involved practitioner. At the interview, circumstances prompting the consideration of investigation or corrective action should be discussed, and the practitioner asked to present relevant information on his/her own behalf. A written record shall be maintained reflecting the substance of the interview with copies sent to the practitioner, the Chief of Staff, and the President/CEO**.** This interview is not a procedural right of the practitioner and shall not be conducted according to or subject to the provisions of Article IX.

In the event that circumstances prompting the interview are based on a Hospital employee's report of alleged practitioner misconduct, the identity of such employee shall not be disclosed to the practitioner but the practitioner shall be informed as to the general and specific allegations contained in such report. If the practitioner knows or thinks s/he knows the identity of any Hospital employee who reports alleged practitioner misconduct, the practitioner shall not under any circumstance contact such employee, directly or indirectly, for any purpose in connection with such report or reporting. The practitioner may contact the President/CEO or President/CEO's designee to request assistance in clarifying any aspect of the employee's allegations.

SECTION 8.3. FORMAL INVESTIGATION

A formal investigation may be initiated by any officer of the Medical Staff, by the Chief of the Clinical Service in which the practitioner exercises privileges, by the President/CEO, by the chair of the Board, or by the Medical Executive Committee.

8.3.1. Requests and Notices. All requests for investigation must be in writing (which may be reflected by minutes), submitted to or created by the Medical Executive Committee, and supported by reference to specific activities or conduct that constitute grounds for the request. The Chief of Staff shall promptly notify the President/CEO of all such requests.

8.3.2. Criteria for initiation: Any person may provide information to any member of the MEC about the conduct, performance, or competence of appointees. When reliable information indicates an appointee may have exhibited acts, demeanor, or conduct reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the hospital; (b) unethical; (c) contrary to the medical staff bylaws, associates manuals, rules and regulations, or medical staff or hospital policies; or (d) below applicable professional standards of behavior or clinical management, a request for an investigation or action against such member may be initiated by the chief of staff, clinical service chief, the President/CEO, the MEC, or the Board.

8.3.3. Formal Investigation. After deliberation, the MEC may either act on the request or direct that a formal investigation be undertaken. The MEC may conduct such investigation itself or may assign this task to a Medical Staff officer, Clinical Service, *ad hoc* committee (consisting of one (1) or more persons), or other organization component. External third parties may be utilized in the investigation

process provided appropriate steps are taken to assure that the activities, when appropriate, are protected by the peer review privilege. The practitioner being investigated will be promptly notified of the investigation and the reason for such investigation and be given an opportunity to respond. The investigative process shall not be a "hearing" as that term is used in Article IX. The investigation may involve consultation with the practitioner involved, with the individual or group making the request, and with other individuals who may have knowledge of the events involved. If the investigation is accomplished by a group or individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as practicable after the assignment to investigate has been made. The MEC may at any time within its discretion, and shall at the request of the Board, terminate the investigation process and proceed with action as provided below.

During an investigation concerning alleged practitioner misconduct based upon a report of such conduct by a Hospital employee, the identity of such employee shall not be disclosed to the practitioner or any other person on behalf of the practitioner, and such employee shall not be contacted, directly or indirectly, by the practitioner or his/her attorney or any other person on behalf of the practitioner where such employee is a current employee of the Hospital. During such investigation, the practitioner (or his/her representative) shall be informed as to the general and specific allegations of any employee's allegations; and may contact the CEO or CEO's designee to request assistance in clarifying any aspect of the employee's report of alleged misconduct.

8.3.4. <u>Medical Executive Committee Action</u>. As soon as practicable after conclusion of the investigative process, if any, but in any event at its next meeting unless deferred, the Medical Executive Committee must act upon the result of such investigation. Its action may include without limitation:

(a) Determine that no corrective action be taken.

(b) Defer action for a reasonable time where circumstances warrant.

(c) Issue a letter of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude a Clinical Service Chief from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letter is issued, the affected Practitioner may make a written response that shall be placed in the Practitioner's file.

(d) Recommend the imposition of terms of probation or special limitation upon continued Medical Staff appointment or exercise of Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring.

(e) Refer the matter to the Medical Staff Wellness Committee for evaluation and action as appropriate for the Practitioner's condition.

(f) Recommend reduction, modification, or suspension of Privileges in excess of fourteen (14) days.

(g) Recommend reduction, modification, or suspension of Medical Staff appointment in excess of fourteen (14) days.

(h) Recommend termination of privileges.

(i) Recommend termination of appointment.

(j) Take other actions deemed appropriate under the circumstances including summary suspension.

8.3.5. <u>Deferral</u>. If additional time is needed to complete its deliberations, the Medical Executive Committee may defer action on the request.

8.3.6. Procedural Rights. A Medical Executive Committee recommendation pursuant to (d) through (j) above shall be deemed adverse and entitle the affected Practitioner to the procedural rights contained in Article IX.

8.3.7. Other Action. A Medical Executive Committee recommendation that does not limit the ability of a practitioner to exercise his or her prerogatives of appointment or privileges is not deemed adverse and shall be transmitted to the Board of Directors together with all supporting documentation for informational purposes.

SECTION 8.4. AUTOMATIC SUSPENSION OR LIMITATION

8.4.1. Imposition of Automatic Suspension or Limitation and Subsequent Process.

The following events shall result in an automatic suspension or limitation of appointment and Privileges without recourse to the procedural rights set forth in Article IX:

8.4.1.1. Licensure. Action by any federal or state authority suspending or limiting an Appointee's professional license shall result in an automatic comparable suspension/limitation on the Appointee's privileges. Whenever an individual's licensure is made subject to probation, the individual's right to practice shall automatically become subject to the same terms of the probation

8.4.1.2. Controlled Substance Authorization. Whenever an Appointee's federal or state controlled substance certificate is suspended, limited, or revoked, the Appointee shall automatically and correspondingly be limited of the right to prescribe medications covered by the certificate as of the time such action becomes effective and through its term. Whenever an individual's state or federal controlled substance certificate is made subject to probation, the individual's right to prescribe such medications shall automatically become subject to the same terms of the probation.

8.4.1.3. Insurance Coverage. If an Appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Appointee's granted privileges that would be affected shall be automatically suspended or restricted as applicable until the matter is resolved and/or adequate professional liability insurance coverage is restored and the Hospital is provided with a written statement from the practitioner (i) explaining the circumstances of the previous insurance being canceled or not renewed and any limitations on the new policy; and (ii) providing a summary of relevant activities during the period of no coverage to establish current competency.

8.4.1.4. Federal Health Program. Whenever an Appointee is suspended from participating in a Federal Health Program (ex. Medicare), the practitioner's appointment and privileges shall be immediately and automatically suspended.

8.4.1.5. Failure to Provide Requested Information. Failure to provide required information pursuant to a written request by the Medical Executive Committee or the President/CEO as set forth herein shall result in automatic suspension of all privileges until the required information is provided. For purposes of this section, "required information" means: (i) physical or mental examination reports if authorized by these Bylaws, or (ii) information regarding a conflict of interest.

8.4.1.6. Failure to Satisfy Continuing Education Requirements. Failure to complete mandated state licensure continuing education requirements shall result in automatic suspension of the Appointee's privileges and prerogatives until such time as the requirements are met.

8.4.1.7. Failure to Pay Dues/Assessments. Failure to pay Medical Staff dues or fines as required within ninety (90) days after notice that such dues or fines are due shall result in an automatic suspension of the Appointee's appointment and privileges until such time as the dues or fines are paid.

8.4.1.8. Failure to obtain NPI. Failure to obtain National Provider Identifier, which is required as part of the Administrative Simplification section of the Health Insurance Portability and Accountability Act.

8.4.2. Impact of Automatic Suspension/Limitation. During such period of time when an Appointee's privileges are suspended or limited, he/she may not exercise any prerogatives of appointment or exercise any privileges at the Hospital, participate in Emergency Department call (exception being automatic suspension for medical records), schedule surgery, or otherwise provide professional services within the Hospital for patients, nor can he or she render professional care except as follows:

(a) To conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the suspension of Privileges.

(b) To attend an obstetrical patient who has been under his or her active care and management and who comes to term and is admitted to the Hospital in labor.

(c) To attend to the management of any patient under his or her care whose admission or outpatient procedure was scheduled prior to the effective date of the suspension.

(d) To attend to the management of any patient requiring emergency care and intervention.

8.4.3. Action Following Imposition. As soon as practicable after the imposition of an automatic suspension, the MEC shall convene to determine if further corrective action is necessary in accordance with Article IX. The lifting of the action or inaction that gave rise to an automatic suspension or limitation on privileges shall result in the automatic reinstatement of the practitioner's appointment and/or privileges provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the practitioner shall be obligated to provide such information as the Medical Staff Office shall reasonably request to assure that all information in the practitioner's credentials file is current.

SECTION 8.5. AUTOMATIC TERMINATION

8.5.1. The following events shall result in an automatic termination of appointment and privileges without recourse to the procedural rights set forth in Article IX.

8.5.1.1 Licensure. Action by any federal or state authority terminating an Appointee's professional license shall result in an automatic termination of the Appointee's appointment and privileges.

8.5.1.2. Insurance. If an Appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than thirty (30) days, the Appointee's appointment and privileges shall automatically terminate as of the thirty-first 31st day.

8.5.1.3. Federal Health Program. Whenever an Appointee is excluded from participating in a Federal Health Program, the Appointee's appointment and privileges shall be automatically terminated.

8.5.1.4. Conduct involving Moral Turpitude. A practitioner's appointment and privileges shall be immediately and automatically terminated if the practitioner has admitted to, or is convicted of a misdemeanor or felony involving moral turpitude as defined in Ohio law.

SECTION 8.6. SUMMARY SUSPENSION

8.6.1. Initiation. A summary suspension may be initiated by an officer of the Medical Staff, chair of the Board, President/CEO and/or designee, or a Clinical Service Chief. Each has the authority to summarily suspend the Medical Staff status or any portion of the privileges of a practitioner whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. A summary suspension is effective immediately, and the President/CEO must give prompt written notice by Special Notice of the suspension to the practitioner. Such summary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual but shall not be considered a complete professional review action in and of itself nor shall it imply any final finding of responsibility for the situation that caused the suspension.

8.6.2. Effective Date. Such suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President/CEO (unless imposed by the President/CEO) who will inform the Board and the Chief of Staff. Such suspension shall remain in effect unless or until modified by the Chief of Staff or the Board.

8.6.3. Care of Patients. If another member of the practitioner's group is unable to assume care, a suspended practitioner's patients then in the Hospital must be assigned to another practitioner by an officer of the Medical Staff or the appropriate Clinical Service Chief. This assignment should consider the wishes of the patient in choosing a substitute practitioner when feasible.

8.6.4. Medical Executive Committee Action. As soon as convenient and generally within seventy-two (72) hours after the summary suspension has been imposed, the Chief of Staff will appoint an *ad hoc* committee**,** (consisting of one (1) or more persons) to consider the action taken. Such committee must submit its report and conclusions within fourteen (14) days to the Medical Executive Committee and to the Professional Practice Committee of the Board. The Medical Executive Committee may recommend modification, continuation, or termination of the terms of the suspension***.***

8.6.5 Procedural Rights. Unless the summary suspension is lifted within fourteen (14) days of its imposition, the Practitioner is entitled to the procedural rights contained in Article IX.

8.6.6. Other Action. A Medical Executive Committee recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights must be transmitted, together with all supporting documentation, to the Board. In this instance, the Medical Executive Committee's recommendation will have the effect of revoking the summary suspension completely or reinstating the practitioner with whatever corrective action was assessed by the Medical Executive Committee preceding the final decision of the Board of Directors.

ARTICLE 9.
HEARING AND APPEAL PROCEDURES

This Article applies to all hearing and appeal procedures of the Medical Staff consistent with Article 7 of the Board of Directors' code of regulations.

SECTION 9.1. INITIATION OF HEARING

An applicant or an individual holding a Medical Staff appointment shall be entitled to a hearing whenever an adverse recommendation has been made by the Medical Executive Committee or an adverse action taken by the MEC or the Board. The hearing shall be conducted pursuant to this Article.

SECTION 9.2. THE HEARING

9.2.1. Notice of Recommendation/Action.

9.2.1.1 When a recommendation is made or action taken which, according to these Bylaws, entitles an individual to a hearing prior to a final decision by the Board, the affected practitioner shall promptly be given notice by Special Notice by the Chief of Staff. This notice shall contain:

(a) A statement of the recommendation made/action taken and the reasons for it.

(b) Notice that the practitioner has the right to request a hearing on the recommendation/action within thirty (30) days of his/her receipt of the notice.

(c) A summary of the rights at the hearing as provided for in these Bylaws.

9.2.1.2 The practitioner shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing. The request must be made in writing, sent by Special Notice, to the Chief of Staff. In the event the affected practitioner does not request a hearing within the time and in the manner herein above set forth, he/she shall be deemed to have waived his/her right to such hearing and to have accepted the action involved**.** The action shall thereupon be referred to the Board for final action.

9.2.2. Grounds for Hearing. Except as otherwise specified in these Bylaws, any one or more of the following actions, provided that it has been recommended by the MEC or taken by the Board under circumstances where no prior right to request a hearing existed, shall be deemed adverse and entitle a Practitioner to request a hearing:

(a) Denial or termination of Medical Staff appointment or reappointment.

(b) Denial of requested advancement in Medical Staff appointment, status, or category.

(c) Suspension of Medical Staff appointment in excess of fourteen (14) days.

(d) Denial or termination of requested Privileges.

(e) Involuntary reduction of existing Privileges for a period of fourteen (14) days or longer.

(f) Suspension of Privileges for a period of fourteen (14) days or longer.

(g) Imposition of individual mandatory prior or concurrent consultation requirement or direct supervision or other form of probation that limits the ability to exercise Privileges.

(h) Denial of reinstatement from a leave of absence,

(i) Imposition of modifications of Privileges or conditions for reinstatement, if a report to the National Practitioner Data Bank is required.

9.2.3. Actions Which Do Not Give Right to a Hearing. Notwithstanding the above provision, no action described in this section shall constitute grounds for or entitle the practitioner to request a hearing.

(a) An oral or written reprimand or warning.

(b) The denial, termination, or suspension of temporary, disaster, or emergency privileges.

(c) Imposition of a probationary period with retrospective or concurrent review of cases provided that such probationary period does not otherwise limit the practitioner's ability to exercise his or her privileges.

(d) Denial of requested privileges because the practitioner failed to satisfy the basic qualifications or criteria of training, education, or experience established for the granting of privileges for a specific procedure or procedures.

(e) Ineligibility for Medical Staff appointment or reappointment or the privileges requested, in whole or in part, because a Department has been closed or there exists an exclusive contract limiting the granting of privileges requested by the practitioner.

(f) Termination of or the inability to exercise privileges either in whole or in part because the Hospital has determined to close a Department or grant an exclusive contract limiting the ability of current Appointees to exercise such privileges.

(g) Termination of the practitioner's employment or other contract for services with the Hospital or through a group contract unless the contract provides otherwise.

(h) Ineligibility for Medical Staff appointment or requested privileges because of lack of facilities, equipment, or because the Hospital has elected not to perform, or does not provide, the service which the practitioner intends to provide or the procedure for which privileges are sought.

(i) Suspension, or revocation of Medical Staff appointment or privileges regarding automatic suspensions and terminations.

(j) Voluntary suspension or relinquishment of privileges or Medical Staff appointment when professional competence or conduct is not at issue.

(k) Voluntary suspension or relinquishment of privileges or Medical Staff appointment that is not in return for the Medical Staff or Board refraining from conducting an investigation based upon professional competence or conduct.

(l) Suspension of appointment or privileges, either in whole or in part, for not more than fourteen (14) days during which time an investigation is being conducted to determine the need for further action.

(m) Any other action that does not relate to the competence or professional conduct of a practitioner.

9.2.4. Notice of Hearing and Statement of Reasons**.** The Chief of Staff is responsible for scheduling the hearing and giving notice, in writing, by Special Notice, to the affected practitioner of the time, place, and date of the hearing. The hearing shall begin as soon as practicable, considering the schedules and availability of all concerned, but in no event earlier than thirty (30) days from the date of

the hearing notice (unless the affected party agrees to an earlier time). The notice shall contain a statement of the reasons for the recommendation/action as well as the list of patient record numbers (if applicable) and information supporting the recommendation/action. This statement and the list of patient record numbers (if applicable) and information it contains may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that individual and his counsel have sufficient time to review this additional information prior to hearing and prepare a response (if any) to it.

9.2.5. List of Witnesses. A written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of the Medical Executive Committee or the Board shall be given with the notice of hearing. The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his/her behalf within ten (10) days after receiving notice of the hearing. The witness list of either party may, at the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

9.2.6. Exhibits. The parties shall cooperate in the exchange of exhibits reasonably in advance of the hearing date. Prior to any exchange of exhibits, the parties must agree that all such documents will be maintained as confidential peer review documents and not be disclosed or used for any purpose other than the hearing and appeals related thereto.

9.2.7. Objections. All objections to witnesses or exhibits to the extent then reasonably known, shall be submitted to the hearing officer in writing in advance of the hearing.

SECTION 9.3. HEARING OFFICER/HEARING PANEL AND PRESIDING OFFICER.

9.3.1. Hearing Officer. The President/CEO (after consultation with the President of Board chair or designee, as applicable) shall appoint a hearing officer (mutually agreeable to both the Chief of Staff and President/CEO) to perform the functions of both hearing officer and presiding officer. The hearing officer may not be in direct economic competition with the practitioner requesting the hearing nor, if the hearing officer is an attorney, may the hearing officer represent clients who are in direct economic competition with the practitioner requesting the hearing. In the event a hearing panel is appointed instead of a hearing officer, all references in this Article to the "hearing officer" shall be deemed to refer instead to the hearing panel, unless the context would clearly otherwise require.

9.3.2. Hearing Panel. As an alternative to a hearing officer, the President/CEO (after consultation with the Chief of Staff or Board chair as applicable) may appoint a hearing panel which shall be composed of not less than three (3) impartial individuals who did not actively participate in the consideration of the matter involved at any previous level. The individuals may be Appointees, practitioners, or lay persons not connected with the Hospital, or any combination of such persons. The President/CEO (or Board chair if the hearing is occasioned by a Board determination) shall designate one (1) of the panel members to act as presiding officer (with the right to vote) or, alternatively, the President/CEO (or Board chair if the hearing is occasioned by a Board determination) may appoint a presiding officer to assist the hearing panel (who may assist the panel in its private deliberations but who shall not have the right to vote). Knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. The hearing panel shall not include any individual who is in direct economic competition with, or any individual who is professionally associated with or related to, the practitioner requesting the hearing.

9.3.3. Failure to Appear. Failure, without good cause, of the affected practitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendation or actions pending without further rights of appeal. The matter shall then be referred to the Board for final decision.

9.3.4. Time Frame, Postponements, and Extensions. A hearing must occur no later than three (3) months after receipt of the request unless postponements or extensions are granted. Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested but shall be permitted only by the President/CEO if a hearing date has not yet been set, or only by the hearing officer after a hearing officer has been appointed. The affected practitioner must make every reasonable effort to be available for the hearing dates established by the President/CEO and/or hearing officer.

9.3.5. Deliberations and Recommendations of the Hearing Officer. Within twenty (20) days after adjournment of the hearing, the hearing officer shall conduct its deliberations outside the presence of any other person except the presiding officer and shall render a written report and recommendation that shall contain a concise statement of the reasons justifying the recommendation made. The report and recommendation, together with the transcript of proceedings and exhibits, shall be delivered to the President/CEO. For purposes of this section, the hearing officer may deem the hearing adjourned at such time as the transcript of proceedings is received or upon the submission of written closing statements by the parties (if applicable) whichever is later.

9.3.6. Disposition of Hearing Officer Report & Recommendation. Upon its receipt, the President/CEO shall forward the hearing officer's report and recommendations, along with all supporting documentation, to the body that issued the adverse recommendation/action. Within fifteen (15) days of receiving the report and recommendation, the initiating body shall make its final recommendation and deliver it to the President/CEO. The President/CEO shall provide a copy of the final recommendation together with the hearing officer's report and recommendation to the practitioner (by Special Notice) and to the Board. The Board shall also be provided with a copy of the transcript of the proceedings and exhibits.

SECTION 9.4. HEARING PROCEDURE

9.4.1. Representation. The affected practitioner shall be entitled to be represented at the hearing by an attorney to examine witnesses and present his/her case. He/She shall inform the President/CEO in writing of the names of that person as soon as the attorney is retained not to be less than 10 days prior to the date of the hearing. The President/CEO may also appoint a person, who may be an attorney, to support the recommendations that gave rise to the hearing and to examine and cross-examine witnesses at the hearing.

9.4.2. Presiding Officer. The President/CEO may appoint an attorney to serve as presiding officer. Such presiding officer may be legal counsel to the Hospital. He/She must not act as a prosecuting officer, or as an advocate for either side at the hearing. He/She may participate in the private deliberations of the hearing panel and be a legal advisor to it, but he/she shall not be entitled to vote on its recommendations. He/She may thereafter continue to advise the Board on the matter.

9.4.2.1. If a hearing officer is appointed, he/she shall act as presiding officer. If a hearing panel is appointed but a presiding officer is not, the chair of the hearing panel shall be the presiding officer.

9.4.2.2. The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He/She shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence, upon which he/she may be advised by legal counsel to the hospital. In all instances he/she shall act in such a way that all information relevant to the continued appointment or privileges of the affected practitioner is considered by the hearing officer in formulating the report and recommendation. It is understood that the presiding officer is acting at all times to see that all relevant information is made available to the hearing officer for its deliberations, report, and recommendation(s) to the Board.

9.4.3. Record of Hearing. A record of the hearing shall be maintained by a court reporter present to make a record of the hearing or a recording of the proceedings. The cost of such court reporter shall be borne by the Hospital. The hearing panel/officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any persons designated by such body and entitled to notarize documents in the state of Ohio.

9.4.4. Rights of Both Sides. At the hearing both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues and to rebut any evidence. If the person requesting the hearing does not testify in his/her own behalf, he/she may be called and examined as it under cross-examination.

At a hearing and in preparation for a fair hearing based upon a Hospital employee's report of alleged practitioner misconduct, the practitioner and his/her representative shall have access to a notarized report or affidavit signed by the reporting employee, which report or affidavit shall disclose the identity of the employee and the specific allegations concerning the practitioner's alleged misconduct. Unless on a voluntary basis, the Hosptial employee making such report or affidavit cannot be requested to personally participate at the hearing. Administrative personnel who have investigated the employee report may be asked to participate at the hearing.

9.4.5. Admissibility of Evidence. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence may be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the hearing panel/officer my request such a memorandum to be filed, following the close of the hearing. The hearing panel/officer may interrogate the witnesses, call additional witnesses, or request documentary evidence if he/she/it deems it appropriate.

9.4.6. Official Notice. The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of the state of Ohio. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

9.4.7. Observers. The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as requested by the Chief of Staff and the President/CEO.

9.4.8. Basis of Report and Recommendation. The decision of the hearing officer shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(a) Oral testimony of witnesses.

(b) Memorandum of points and authorities presented in connection with the hearing.

(c) Any information regarding the affected Practitioner so long as that information has been admitted into evidence at the hearing and the affected Practitioner had the opportunity to comment on and, by other evidence, refute it.

(d) Any and all applications, references, and accompanying documents.

(e) All officially noticed matters.

(f) Any other evidence that has been admitted.

9.4.9. Burden of Proof. At the hearing, the following rules governing the burden of proof shall apply:

(a) The body triggering the hearing shall first come forward with evidence in support of its recommendation/action.

(b) The burden shall then shift to the affected practitioner to come forward with evidence in his/her support.

(c) The triggering body may then submit evidence in rebuttal to that presented by the affected practitioner.

(d) In order to prevail, the affected practitioner must establish that the recommendation/action that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

9.4.10. Attendance By Hearing Panel Members. In the event a hearing panel is chosen, and recognizing that it may not be possible for all members of the hearing panel to be present continually at all sessions of the panel, the hearing may continue provided at least two (2) members of the hearing panel are present at all times. The fact that certain panel members were not physically present at all times during the hearings will not disqualify them or invalidate the hearing. The vote shall be by majority of those appointed to the hearing panel.

9.4.11. Adjournment and Conclusion. The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

SECTION 9.5. APPEAL

9.5.1. Time for Appeal**.** Within ten (10) days after the affected practitioner is notified of the triggering body's final recommendation/action, and provided such recommendation/action continues to be adverse, he/she may request an appellate review. The request shall be in writing, be delivered to the President/CEO by Special Notice, and include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, the affected individual shall be deemed to have accepted the final recommendation/action, and it shall thereupon be referred to the Board for final action.

9.5.2. Grounds for Appeal. The grounds for appeal from an adverse recommendation-/action are limited to:

(a) There was substantial failure on the part of the Medical Executive Committee or hearing officer to comply with the Medical Staff Bylaws in the conduct of hearings and/or recommendations/actions based upon hearing so as to deny procedural due process.

(b) The recommendation/action was made arbitrarily, capriciously or with prejudice.

(c) The recommendation/action was not supported by the evidence.

9.5.3. Time, Place, and Notice**.** Whenever an appeal is requested and is consistent with the grounds for appeal as set forth in the preceding sections, the President/CEO (after consultation with the Board chair) shall promptly schedule and arrange for an appellate review. The President/CEO shall give the affected practitioner notice of the time, place, and date of the appellate review.

9.5.4. Nature of Appellate Review

9.5.4.1. Review Panel. The Board may hear the appeal as a whole or the chair may appoint a subcommittee composed of not less than three (3) Board members.

9.5.4.2. Additional Evidence. In the event a party seeks to submit additional evidence at the appeal, it will be considered only if the Review Panel determines, at its discretion, that (1) the party seeking to admit it has demonstrated that he/she was unfairly deprived of the opportunity to admit it at the hearing; or (2) the information was not known, and on the basis of reasonable efforts could not have been known, at the time of the hearing. The Review Panel, at its discretion, shall decide whether to (1) hear the evidence, subject to the same rights of cross-examination or confrontation provided at the hearing; or (2) remand the matter back to the hearing officer and direct that the hearing be re-opened. In the latter case, the hearing officer shall be required to submit an amended report and recommendation to the triggering body and the provisions of §§10.3.5 and 10.3.6 shall thereafter apply.

9.5.4.3. Written Statements and Oral Arguments. Each party shall have the right to present a written statement in support of his/her position on appeal, and at its sole discretion, the Review Panel may allow each party or its representative to appear personally and present oral arguments. The Review Panel, if consisting of less than the full Board, shall recommend final action to the Board. Its recommendation shall be in writing and supported by the reasons for such recommendation.

9.5.5. Final Decision of the Board

9.5.5.1. Board Decision. If the appellate review is conducted by the Board as a whole, the Board may render its final decision upon conclusion of the appellate review or may defer rendering its final decision until its next regularly scheduled Board meeting. If the appellate review is conducted by a subcommittee of the Board, the Board shall render its final decision at its next regularly scheduled Board meeting following receipt of the subcommittee's written recommendation. In such event, the Board may affirm, modify, or reverse the recommendation of the subcommittee or, at its discretion, refer the matter back to the subcommittee or the hearing officer for further action. The President/CEO shall then be responsible for notifying the MEC and the affected practitioner (by Special Notice), in writing, of the Board's final decision.

9.5.5.2. Reporting Obligations. If the recommendation of the Board is an Adverse Review Action, the final decision of the Board shall include the actual coding and a description of the underlying action which will be reported to the National Practitioner Data Bank.

9.5.6. Further Review. Except where the matter is referred for further action and recommendation in accordance with this Article, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board should not, except for good cause shown as determined by the Board, exceed thirty (30) days in duration.

9.5.7. Right to One Appeal Only. No practitioner shall be entitled as a matter of right to more than one (1) appellate review on any single matter that may be the subject of an appeal, without regard to whether such subject is the result of action by the Medical Executive Committee or hearing officer, or a combination of acts of such bodies. In the event that the Board ultimately determines to deny initial appointment or reappointment to the Medical Staff or privileges to an applicant, or to revoke or terminate the Medical Staff appointment and/or privileges of an Appointee, that individual may not again apply for Medical Staff appointment or privileges at the Hospital for a period of two years from the final Board decision, unless the Board's decision provides otherwise.

SECTION 9.6. REPRESENTATION BY COUNSEL

At such time as the practitioner, Medical Executive Committee, or Board is represented by legal counsel, then all notices required to be sent herein may be served upon the practitioner or MEC/Board's legal counsel, and the requirement that such notices be sent by Special Notice is hereby waived; rather, such notices may be sent by regular first class U.S. mail.

ARTICLE 10.
REVIEW, REVISION, ADOPTION AND AMENDMENT

SECTION 10.1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review, adopt, and recommend to the Board Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of related Manuals, Rules & Regulations, policies, and protocols developed to implement various sections of these Bylaws. Neither the Board nor the Medical Staff may unilaterally amend or nullify the Medical Staff Bylaws, or other related medical staff governance documents. Rather, the provisions set forth in this Article X shall be the sole means for creating or adopting such documents**.**

SECTION 10.2. METHODS OF ADOPTION AND AMENDMENT

Medical Staff Bylaws may be adopted, amended or repealed by the following actions:

10.2.1. Medical Executive Committee Action: The Medical Executive Committee may make corrections and changes when such correction or change is necessary due to a change in law, or due to clerical error such as spelling, punctuation, or grammar. These changes may be approved by the affirmative vote of two-thirds (2/3rds) of the Medical Executive Committee members. No prior notice to the Medical Staff of such change is required. All changes thus made will be reported at the next scheduled general meeting of the Medical Staff.

10.2.2. Medical Staff Action. The Bylaws may be amended by the affirmative vote of two-thirds (2/3) of the active Appointees present at a regular or special meeting of the Medical Staff provided that a copy of the proposed documents or amendments was given to each active Appointee not less than twenty-one (21) days in advance of the meeting and provided that each active Appointee was notified that such matter would come to vote at the meeting. Absentee ballots are permitted.

10.2.3. Board Action. No amendment shall become effective until it is approved by the Board.

SECTION 10.3. RELATED MEDICAL STAFF GOVERNANCE DOCUMENTS

MEC may develop and amend manuals and policies provided that such documents are approved by a two-third (2/3) vote of the MEC. The development and amendment of such manuals and policies will not require the approval of the active Medical Staff. Such manuals and policies must be consistent with the Bylaws. Any such manual or policy, or amendments thereto, shall not become effective until approved by the Board. The Medical Staff will be notified of any such documents or amendments, and they will be available in the Medical Staff Services Department At the time of appointment, reappointment, or other grant of privileges, a current copy of the Bylaws, Organization Manual, and, Credentials Manual will be made available to allow the practitioner to attest to reading and abiding by them.

SECTION 10.4. BOARD ACTION

10.4.1. Conflict with MEC/Medical Staff Recommendation. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. The President/CEO will schedule such conference within fourteen (14) days after receipt of a request for a conference from the Chief of Staff. The Board may then take final action.

10.4.2. Board-Initiated Action. The Board may adopt amendments to Bylaws, Rules & Regulations, Manuals, or Medical Staff policies provided that the Board has first proposed its recommended changes to the MEC, and the MEC has declined to adopt such amendments. In such event, the Board shall then present the recommended changes to the ad hoc Joint Conference Committee for its recommendation prior to adopting any such amendment.

10.4.3. Conflict within Documents. If a change to the Board's code of regulations results in a conflict with the Medical Staff Bylaws, then the Board's code of regulations shall control; provided, however, that such conflict shall then be referred to the ad hoc Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved. If there is a conflict between a manual or policy and the Bylaws, the Bylaws shall control. Such conflict shall then be reviewed by the MEC to determine how such conflict can be resolved.

ARTICLE 11.
CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 11.1. SPECIAL DEFINITIONS

For purposes of the Article, the following definitions shall apply:

- INFORMATION means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearing, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in §11.5.

- PRACTITIONER means an Appointee or applicant.

- REPRESENTATIVE means the Board of Directors of the Hospital and any director or committee thereof; the President/CEO or the President/CEO's designee; registered nurses and other employees of the Hospital; the Medical Staff organization and any Appointee, officer, Clinical Service, or committee thereof; any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

- THIRD PARTIES means any individual or organization providing information to any Representative.

SECTION 11.2. AUTHORIZATIONS AND CONDITIONS

By submitting an application for Medical Staff appointment or reappointment or by applying for or exercising privileges or providing specified patient care services at the Hospital, a practitioner:

(a) Authorizes Representatives to solicit, provide and act upon information bearing on his or her professional ability and other qualifications.

(b) Agrees to be bound by the provisions of the Article and to waive all legal claims against any Representative who acts in accordance with the provisions of the Article.

(c) Acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Medical Staff appointment and the

continuation of such appointment and to his/her exercise of Privileges or provisions or specified patient care services at the Hospital.

SECTION 11.3. CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, or determining that health care services are professionally indicated or were performed in compliance with the applicable standards of care or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided to third parties. This information shall not become part of any particular patient's record. It is expressly acknowledged by each practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff appointment and privileges or specified services.

SECTION 11.4. IMMUNITY FROM LIABILITY

11.4.1. For Action Taken. No representative of the Hospital or Medical Staff shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his or her duties as a representative, unless such representative acts on the basis of false information knowing it to be false, after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement, or recommendation is warranted by such facts.

11.4.2. For Providing Such Information. No representative of the Hospital or Medical Staff and no Third Party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a practitioner who is or has been an Applicant to or Appointee of the Medical Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital, provided that such representative or Third Party does not act on the basis of false information knowing it to be false, and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

SECTION 11.5. ACTIVITIES AND INFORMATION COVERED

11.5.1. Activities. The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) Applications for appointment, privileges, or specific services.

(b) Periodic reappraisals for reappointment, privileges or specific services.

(c) Corrective actions, recommended or taken.

(d) Hearings and appellate reviews.

(e) Performance improvement/quality assessment activities.

(f) Utilization review activities.

(g) Claims reviews.

(h) Profiles and profile analysis.

(i) Risk management activities.

(j) Other Hospital, committee, Clinical Service, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.5.2. Information. The information referred to in this Article may relate to a practitioner's professional licensure or certification, education, training, clinical competency, judgment, utilization practices, character, ability to fully and competently carry out the privileges requested, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency, or appropriateness of patient care provided in the Hospital.

SECTION 11.6. RELEASES

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements as may be applicable under the state of Ohio and federal law. Execution of such releases is not a prerequisite to the effectiveness of this Article.

SECTION 11.7. CUMULATIVE EFFECT

Provisions in these Medical Staff Bylaws and in application forms relating to authorization, confidentiality of information, and immunities from liability are in addition to other protections provided by state and federal law and not in limitation thereof.

CERTIFICATION OF ADOPTION AND APPROVAL

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff Bylaws, Rules & Regulations, policies, or Manuals pertaining to the subject matter thereof.

Adopted by the Medical Executive Committee on

April 21, 2009

Adopted by the Medical Staff on

May 28, 2009

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Shachi Rattan, M.D.
Chief of Staff

Approved and adopted by the Board of Directors on
May 7, 2009
pending a favorable recommendation by the Medical Staff

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Roy Chew
President/CEO