MEDICAL STAFF BYLAWS
OF
MEASE COUNTRYSIDE HOSPITAL

ARTICLE 1
GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in these Bylaws and related policies and manuals:

(1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") mean individuals other than Medical Staff Members who are authorized by law and by the Hospital to provide patient care services. Only those specific categories of AHPs that have been approved by the Board shall be permitted to practice at the Hospital. All Allied Health Professionals providing services at Mease Countryside Hospital are classified as Advanced Dependent Practitioners, which means that they provide a medical level of care or perform procedures consistent with the granted clinical privileges and are required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement. See Appendix A.

(2) "BOARD" means the Board of Trustees of the Hospital which has the overall responsibility for the Hospital, or its designated committee.

(3) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), or the American Board of Podiatric Surgery, as applicable, upon a physician, dentist or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

(4) "PRESIDENT OF THE HOSPITAL" means the individual appointed by the board to act on its behalf in the overall management of the hospital.

(5) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the Board consistent with these Bylaws to act as the chief medical officer of the Hospital.

(6) "CHIEF OPERATING OFFICER" ("COO") means the individual appointed by the board to assist the Chief Executive Officer of the hospital.

(7) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services and includes access to hospital resources, equipment and personnel necessary to exercise the clinical privileges granted.

(8) "DAYS" means calendar days.

(9) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(10) "HOSPITAL" means Mease Countryside Hospital.

(11) "IN GOOD STANDING" means, at the time of the assessment of standing, his/her membership and/or privileges are not involuntarily limited, restricted, suspended, (excluding leaves of absence) or otherwise encumbered for disciplinary reasons.

(12) INVESTIGATION means a process specifically instigated by the medical executive committee to determine the validity, if any, to a concern or complaint raised against a medical staff member or individual holding clinical privileges, and does not include activity of the medical staff wellness committee. An investigation has begun when the Medical Executive Committee formally resolves to begin an investigation.

(13) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Executive Committee of the Medical Staff.

(14) "MEDICAL RECORDS" means documentation of patient care containing all information required in a suitable electronic or paper format as designated by the Hospital and the Rules and Regulations and Policies of the Medical Staff.

(15) "MEDICAL STAFF" means all physicians, dentists, podiatrists and psychologists who are members of the medical staff, pursuant to these bylaws. Allied Health Professionals are not appointed to the Medical Staff and shall not be entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

(16) "MEDICAL STAFF LEADER" means any Medical Staff officer, department Chairman, clinical specialty section Chairman, or committee Chairman.
"MEMBER" means any physician, dentist, podiatrist, or psychologist who has been granted Medical Staff membership and clinical privileges by the Board to practice at the Hospital.

"NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, or hand delivery.

"PATIENT CONTACTS" includes any admission, consultation or procedure in any the Hospital.

"PERMISSION TO PRACTICE” means the authorization granted to AHPs by the Board or CEO, as applicable, to exercise clinical privileges.

"PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

"PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

"PRACTITIONER" means unless otherwise expressly limited, any appropriately licensed physician or dentist or podiatrist or psychologist applying for or exercising clinical privileges in the Hospital.

"PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

"PSYCHOLOGIST" means an individual with a Ph.D. in clinical psychology.

"SEXUAL HARRASSMENT" means unwelcome sexual advances, requests for sexual favors, or verbal, visual or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions, unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

"SPECIAL NOTICE" means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt.

"SUPERVISING PHYSICIAN” means the individual with clinical privileges who has agreed in writing to supervise or collaborate with an AHP while that practitioner is practicing in the Hospital.

"UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have a Primary Physician or applicable specialist or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

"VICE PRESIDENTS FOR MEDICAL AFFAIRS" ("VPMAs") means the individuals appointed by the Board after Medical Staff input consistent with these bylaws to assist the chief medical officer of the Hospital.

1.B. TIME LIMITS
Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS
When a function is to be carried out by a Member of Hospital management, by a Medical Staff member, or by a Medical Staff Committee, the individual, or the committee through its chairman, may delegate performance of the function to one or more qualified designees.

1.D. MEDICAL STAFF FUNDS
(1) Biennial Medical Staff dues shall be set annually in October for the following year by the Medical Executive Committee in an amount no less than $100, and may vary by category. The Medical Executive Committee may require assessments, which may vary by membership category, as appropriate.

(2) Dues shall be payable every two years upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital’s Medical Staff account shall be the President of the Medical Staff and President-Elect of the Medical Staff or the designee.

(4) Application fees shall be set by the Medical Executive Committee and shall be payable to the Hospital and will be deposited to the appropriate medical staff fund.

Except as provided in these bylaws or approved by the Medical Executive Committee, medical staff members shall not be subject to fines, assessments or any other payments to the hospital by virtue of medical staff membership or privileges.
ARTICLE 2
QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Eligibility Criteria:
To be eligible to apply for initial or renewed Medical Staff membership, permission to practice, and/or clinical privileges (except temporary privileges, the criteria for which are set forth in 5.B. of these Bylaws) the Hospital, physicians, dentists, podiatrists, psychologists, and AHPs must, as applicable to that category of practitioner:
(a) have a current, unrestricted license or registration to practice in this state, which is not subject to any probationary terms or conditions not generally applicable to all licensees, and have never had a license or registration to practice revoked or suspended by any state licensing agency;
(b) where applicable to their practice, have a current, unrestricted DEA registration;
(c) be located close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Executive Committee and Morton Plant Mease Healthcare;
(e) not be currently excluded from participating in Medicare, Medicaid or any other federal or state health care program when such exclusion has been imposed by government enforcement authorities, or accepted by the practitioner, as a sanction for unlawful conduct and have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
(f) have never had Medical Staff appointment clinical privileges, or permission to practice denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or permission to practice, or relinquished privileges, during a Medical Staff investigation or in exchange for not conducting such an investigation;
(g) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, -violence.
(h) agree to fulfill all responsibilities regarding emergency call as determined by the Medical Executive Committee
(i) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;
(j) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association. A clinical psychologist must have obtained a Ph.D. in Psychology from a university which program is approved by the American Psychological Association and must demonstrate completion of at least two years of training involving clinical experience in accordance with the guidelines of the American Psychological Association, including one year of internship in an American Psychological Association approved facility. Dentists who will not exercise surgical privileges need not demonstrate completion of a residency program;
(k) be board certified in their primary area of practice at the Hospital. Those applicants who are not board certified at the time of application shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within three years from the date completion of residency or fellowship training.. A member who does not attain subspecialty certification may remain a member of the Medical Staff, provided he or she is certified in the primary
area of practice. Eligibility to request privileges shall be limited to the area in which certification has been achieved;

(l) demonstrate active clinical practice during at least two of the last four years; and

(m) if seeking to practice as an AHP, have a supervision agreement and/or collaborative agreement with a physician who is appointed to the Medical Staff and who has appropriate clinical privileges (the “Supervising Physician”); and

(n) satisfy any Hospital-specific eligibility criteria related to medical staff membership and/or clinical privileges that may be adopted by the Medical Staff at the Morton Plant Mease Healthcare Hospital to which they are applying.

2.A.2. Waiver of Criteria:
   (a) Any individual who does not satisfy one or more of the criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

   (b) A request for a waiver will be submitted to the relevant Hospital MEC(s) for consideration. In reviewing the request for a waiver, the Hospital MEC(s) may consider the specific qualifications of the individual in question, input from the relevant Department Chairman, and the best interests of the Hospital and the communities it serves. Additionally, the Hospital MEC may, in its discretion, consider the application form and other information supplied by the applicant. The Hospital MEC’s recommendation will be forwarded to the Hospital Board. Any recommendation to grant a waiver must include the basis for such.

   (c) The Hospital Board will review the recommendation of the Hospital MEC and determine whether to grant a waiver.

   (d) No individual is entitled to a waiver, or to a hearing solely because the Hospital Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of membership or clinical privileges.

   (e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

   (f) An application for membership, clinical privileges, or permission to practice that does not satisfy an eligibility criterion will not be processed until the Hospital Board has determined that a waiver should be granted following this procedure.

2.A.3. Factors for Evaluation:
   Only those individuals who can document that they are qualified in all regards will be granted Medical Staff membership or permission to practice at the Hospital. The following factors will be evaluated as part of the membership processes:

   (a) relevant training, experience, demonstrated current competence, and judgment;

   (b) adherence to the ethics of their profession;

   (c) good reputation and character;

   (d) ability to perform, safely and competently, the clinical privileges requested;

   (e) ability to work harmoniously with all members of the patient care team; and

   (f) recognition of the importance of, and willingness to support, Morton Plant Mease Health Care’s, BayCare Health System’s, and the Hospital’s commitment to quality care, and recognition that interpersonal skills at collaboration, communication, and collegiality are essential for the provision of quality patient care.

2.A.4. No Entitlement to Membership:
   No individual is entitled to receive an application or to Medical Staff membership, clinical privileges, or permission to practice at the Hospital merely because he or she:

   (a) is licensed to practice a profession in this or any other state;

   (b) is a member of any particular professional organization;

   (c) has had in the past, or currently has, Medical Staff membership or privileges at any hospital or health care facility;

   (d) resides in the geographic service area of the Hospital;
2.A.5. Nondiscrimination:
No individual will be denied membership, permission to practice, or clinical privileges on the basis of sex, sexual orientation, gender or gender orientation, race, creed, age, religion, color or national origin or the member’s legitimate professional or business interests.

2.B. GENERAL CONDITIONS OF MEMBERSHIP
2.B.1. Basic Responsibilities and Requirements:
As a condition of consideration for membership, permission to practice, and/or clinical privileges, and as a condition of continued membership, permission to practice, and/or clinical privileges, every practitioner specifically agrees to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility;
(b) to abide by all Bylaws, policies, and Rules and Regulations, as may be amended from time to time, in force during the time the individual is appointed;
(c) to accept committee assignments, emergency service call obligations, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned by the medical staff;
(d) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her medical specialty, including those related to national patient safety initiatives and core measures;
(e) to comply with medical staff adopted protocols and pathways or document reasons for variance;
(f) to provide to the CMO/VPMA immediately, as it occurs, with or without request, new or updated information that is pertinent to any question on the application form;
(g) to immediately submit to a blood and/or urine test, or any other immediate physical or mental evaluation as specified by the chairman of the Medical Staff Health Committee or if unavailable, the President of the Medical Staff or his or her designee. The health care professional(s) to perform the testing and/or evaluations will be determined by the chairman of the Medical Staff Health Committee;
(h) to appear for personal interviews in regard to an membership application;
(i) to use the Hospital sufficiently to allow continuing assessment of current competence or, if the individual has minimal activity at the Hospital, to submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further;
(j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
(k) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
(l) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
(m) to seek consultation whenever necessary as defined in department rules and regulations;
(n) to participate in monitoring and evaluation activities;
(o) to complete in a timely manner all medical and other required records, containing all information required by the Hospital;
(p) to comply with hospital policy regarding patient privacy;
(q) to conduct himself/herself at all times in a cooperative and professional manner;
(r) to promptly pay any applicable dues, assessments and/or fines imposed by the medical staff;
(s) to satisfy continuing medical education requirements; and
(t) to maintain membership in good standing on the medical staff of Mease Dunedin Hospital;
that any misstatement in, or omission from an application for medical staff membership, membership renewal, or clinical privileges, is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there will be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The System Credentials Committee will review the individual's response and provide a recommendation to the MEC. The MEC will recommend to the Board whether the application should be processed further; and

(v) to perform H&Ps in accordance with the requirements of these Bylaws and any applicable policies governing medical record documentation.

2.B.2. Burden of Providing Information:
(a) Individuals who seek or submit an application for membership, permission to practice, and/or clinical privileges have the burden of producing information deemed adequate by the medical staff department and committees involved in credentialing and Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts regarding the same.
(b) Individuals have the burden of providing evidence that all the statements made and information given on the application are accurate.
(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required will be deemed to be withdrawn.
(d) The individual applying for membership is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2.B.3 Provisional Status & Focused Professional Practice Review
(a) Initial appointment to the Medical Staff (regardless of the staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional.
(b) During the provisional period, the practitioner's exercise of the relevant clinical privileges will be subject to focused professional practice evaluation by the chair of the department in which the practitioner has clinical privileges. This focused professional practice evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review, and information obtained from other physicians and Hospital employees. The numbers and types of cases to be reviewed shall be determined by the System Credentials Committee after recommendations from the departments and/or specialty sections.
(c) During the provisional period, the practitioner must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the department chief chairman and/or section chief or other designated physicians.
(d) A new member of the Medical Staff or new AHP shall automatically relinquish his or her appointment, permission to practice, and privileges at the end of the provisional period, and be ineligible to reapply for initial appointment or privileges for two years, if that new member fails, during the provisional period, to:
(1) participate in the required number of cases;
(2) cooperate with the FPPE process including monitoring and review conditions;
(3) participate in medical staff orientation;
(4) fulfill all requirements of appointment and permission to practice, as applicable, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities.

Amended 3/2014
(e) If a current member of the Medical Staff or a current AHP who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the FPPE process, including monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The individual may not reapply for the privileges in question for two years.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for membership and permission to practice will contain a request for specific clinical privileges and will require detailed information concerning the individual's professional qualifications.

(b) In addition to other information, the applications will seek the following:

(1) information as to whether the applicant's medical staff membership, permission to practice, or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's pending professional liability, final judgments, and or settlements; including the substance of the allegations as well as the findings and the ultimate disposition; and any additional relevant information concerning such proceedings or actions as the System Credentials Committee, the MEC, or the Board may reasonably request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a government-issued photo identification.

(c) The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of membership or permission to practice.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for membership, permission to practice, or clinical privileges, the individual expressly accepts the following conditions, whether or not membership, permission to practice, or clinical privileges are granted, throughout the term of membership and permission to practice and the term of any clinical privileges, and, as applicable, to any third-party inquiries received after the individual leaves the Hospital about his/her tenure at the Hospital.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and third parties who conduct credentialing and peer review activities or provide information relating to membership, permission to practice, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual that are made, or taken, or received by the Hospital, its authorized agents, or the medical staff and third parties who provide information relating to the individual. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff or continued permission to practice, and (2) to obtain any and all communications,
reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request and agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:
The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for membership, permission to practice, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Hearing and Appeal Procedures:
Medical Staff applicants members, and all practitioners who apply for or are granted clinical privileges or permission to practice agree that when professional practice evaluation, collegial intervention, or corrective action is initiated or taken against them pursuant to these Bylaws or when an adverse recommendation or decision as defined in these bylaws is made, they will exhaust the remedies provided in these Bylaws as a prerequisite to resorting to any other action, and any failure to fully exhaust the remedies provided herein shall operate as a waiver of any and all causes of action against the hospital, the medical staff, and any representative thereof, relating to the subject professional practice evaluation, collegial intervention, corrective action, or adverse recommendation or decision.

(f) Authorization to Share Information among Components of the System:
The individual specifically authorizes the Hospital and its components to share credentialing and peer review information within the system pertaining to the individual's clinical competence and/or professional conduct. For purposes of this section, a component is any health care organization or facility that is controlled by the same Board as the Hospital. This information may be shared at any time during the individual's term at the Hospital.

ARTICLE 3
APPLICATION PROCEDURE

3.A. PROCEDURE FOR INITIAL MEMBERSHIP

3.A.1. Application:
(a) Applications for appointment, permission to practice, and clinical privileges will be submitted electronically on forms approved by the Board, upon recommendation by the MEC and System Credentials Committee.

(b) Any individual requesting an application for initial membership or permission to practice shall complete a pre-application via electronic format (online) through the Credentials Verification that outlines the threshold eligibility criteria for membership, or permission to practice, and clinical privileges. A completed online pre-application form with copies of all required documents must be received by the Credentials Verification Office. Individuals who fail to meet these eligibility criteria shall not be given an application and shall be notified that they are ineligible to apply. There is no right to a hearing on a determination of eligibility.

(c) Applications may be provided to Residents/Fellows who are in the final six months of their training. Final action will not be taken until all applicable eligibility criteria are satisfied.

3.A.2. Initial Review of Application:
(a) A completed application form with copies of all required documents must be completed online with the Credentials Verification Office. The application must be accompanied by the application fee and a photograph of the applicant.

(b) As a preliminary step, the application will be reviewed by the Credentials Verification Office to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. The CMO/VPMAs of the
Morton Plant Mease Hospitals will assist the Credentials Verification Office with this task. Individuals who fail to complete the online application process or fail to meet the threshold criteria will be notified that their applications will not be processed.

(c) The Credentials Verification Office with the assistance of the CMO/VPMAs, will oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3. Steps to Be Followed for All Initial Applicant

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, Supervising Physician (for an AHP), and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following individually or in combination: the department chair(s) at the Hospital, the System Credentials Committee, a System Credentials Committee representative, the MEC(s), the President of the Medical Staff(s), and/or the VPMA(s).

3.A.4. Department Chairman Procedure:

(a) The department chairman will review the applicant's credentials file prepare a written report regarding whether the applicant has satisfied all of the qualifications for membership and the clinical privileges requested.

(b) For individuals applying to practice at more than one Morton Plant Mease Health Care Hospital, the appropriate department chairman at each of the Hospitals shall receive notice of the application. Those department chairmen will evaluate the applicant, including review of the documentation of the evaluation of the applicant's ability to perform the privileges requested. If there are any specific health concerns then the department chairman may require the applicant to appear before the Medical Staff Physician Health Committee. This committee will make a recommendation within 30 days to resolve any reasonable concerns regarding the applicant's physical and/or mental ability to perform the privileges requested. Failure to comply with the Medical Staff Physician Health Committee recommendations or requirements within the time stipulated will terminate the application process. When multiple department chairmen are involved, they shall coordinate their review(s) so that the evaluation is accomplished within a reasonably prompt time frame.

(c) In the written report, the department chairman shall bring any reasonable concerns regarding the applicant's ability to perform the privileges requested to the attention of the Credentials Committee.

(d) The department chairman will be available to the System Credentials Committee, MEC, and the Board to answer any questions that may be raised with respect to that chairman's report and findings.

3.A.5. System Credentials Committee Procedure:

(a) The System Credentials Committee will review and consider any concerns raised in the report prepared by the relevant department chairman (or chairmen) and will make a recommendation.

(b) The System Credentials Committee may use the expertise of the department chairman, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for membership and/or privileges, the System Credentials Committee will review the applicant's attestation for being physically and mentally able to perform the privileges requested to determine if there is any question
about the applicant's ability to perform the privileges and the responsibilities of membership. If concern is raised, the System Credentials Committee may require the applicant to appear before the Medical Staff Physician Health Committee for evaluation of any health concerns. The Physician Health Committee will report their assessment and recommendation within 30 days. The assessment and recommendations of the Medical Staff Physician Health Committee will be made available to the System Credentials Committee for its consideration. Failure of an applicant to comply with the Medical Staff Physician Health Committee recommendations or requirements within a reasonable time after being requested to do so in writing by the System Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application will cease.

(d) The System Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues. The System Credentials Committee may also recommend that membership be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(de) If the recommendation of the System Credentials Committee is delayed longer than 60 days, the Chairman of the System Credentials Committee will send a letter to the applicant, with a copy to the President of the Medical Staff, CMO/VPMA, and the President of the Hospital, explaining the reasons for the delay.

3.A.6. MEC Recommendation:
(a) At its next regular meeting after receipt of the written findings and recommendation of the System Credentials Committee, the applicable - MEC(s) will:
(1) adopt the findings and recommendation of the System Credentials Committee, as its own; or
(2) refer the matter back to the System Credentials Committee for further consideration and responses to specific questions raised by the Hospital MEC prior to its final recommendation; or
(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the System Credentials Committee's recommendation.

(b) If there is a disagreement between two or more MECs concerning an applicant, the matter will be referred back to the System Credentials Committee, which shall meet with representatives from each applicable MEC to attempt to resolve the differences. If the differences cannot be resolved at that level, the matter shall be referred to a Subcommittee of the MECs, composed of the Chairman of each relevant MEC which shall resolve the differences and forward its recommendation to the Hospital MECs for reconsideration.

(c) If the recommendation of the MEC is to appoint, the recommendation will be forwarded to the Hospital Board through the President of the Medical Staff Hospital.

(d) If the recommendation of the Hospital MEC would entitle the applicant to request a hearing, the MEC will forward its recommendation to the President of the relevant Hospital, who will promptly send special notice to the applicant. The President of the Hospital will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:
(a) Board may delegate to a committee, consisting of at least two members of that Board, action on membership, permission to practice and clinical privileges if there has been a favorable recommendation from the System Credentials Committee and the Hospital MEC and there is no evidence of any of the following:
(1) a current or previously successful challenge to any license or registration;
(2) an involuntary termination, limitation, reduction, denial, or loss of appointment, or privileges at any other hospital or other entity; or
(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment or settlement against the applicant.
Any decision reached by the Hospital Board Committee to appoint will be effective immediately and will be forwarded to the full Hospital Board for consideration at its next meeting.

(b) Upon receipt of a recommendation for membership, permission to practice and/or clinical privileges, the Hospital Board may:
   (1) appoint the applicant or grant permission to practice, and grant clinical privileges as recommended by the Executive Committee or ratify the appointment and clinical privileges granted by the Board Committee, as appropriate; or
   (2) refer the matter back to the System Credentials Committee or Hospital MEC or to another source inside or outside the Hospital for additional research or information; or
   (3) reject or modify the recommendation if it is not substantiated by the facts or is otherwise inconsistent with these bylaws.

(c) If the applicable Hospital Board determines to reject a favorable recommendation, it should first discuss the matter with the Chairman of the System Credentials Committee and the Chairman of the applicable Hospital MEC. If the Hospital Board's determination remains unfavorable to the applicant, the President of that Hospital will promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities as required by state or federal law.

3.A.8. Time Periods for Processing:
   Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete.

3.B. PROVISIONAL STATUS
3.B.1. Duration of Provisional Period:
   (a) All initial Medical Staff memberships at a Morton Plant Mease Health Care Hospital (regardless of the category of the staff) and all initial clinical privileges will be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the System Credentials Committee.
   (b) All grants of increased clinical privileges are also provisional. The duration and/or terms of this provisional period will be recommended by the System Credentials Committee, after consulting with the applicable department chairman, and approved by the Hospital Board.
   (c) During the provisional period, the individual will be evaluated by the chairman of the applicable Hospital department(s) in which the individual has clinical privileges and by the relevant committees as to the individual’s clinical competence and general conduct within the Morton Plant Mease Health Care System.

3.C. PROCEDURE FOR RENEWAL
All terms, conditions, requirements, and procedures relating to initial membership and permission to practice, and clinical privileges will apply to continued membership, permission to practice, and clinical privileges.

3.C.1. Eligibility for Renewal:
   To be eligible to apply for renewal of membership or permission to practice and clinical privileges, an individual must have, during the previous membership term:
   (a) completed all medical records;
   (b) completed all continuing medical education requirements;
   (c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
   (d) continued to meet all qualifications and criteria for membership and the clinical privileges requested;
(e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking membership renewal who has minimal activity at the Morton Plant Mease Healthcare Hospitals must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further; and

(f) paid the membership renewal processing fee.

3.C.2. Factors for Evaluation:

(a) Information considered for all practitioners: In considering an application for reappointment or renewal of privileges or permission to practice, the factors listed in Section 2.A.3 of these Bylaws will be considered, as will the following additional factors relevant to the individual's previous term:

(i) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff;
(ii) participation in applicable Medical Staff duties, including committee assignments and emergency call, if any, as determined under these bylaws;
(iii) behavior at the Hospitals, including the ability to work harmoniously with all members of the patient care team,
(iv) use of the Hospital’s facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
(v) current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff membership or permission to practice;
(vi) capacity to satisfactorily treat patients as indicated by the results of the Hospital’s performance improvement and professional and peer review activities;
(vii) data from the ongoing professional practice evaluation (OPPE) and focus professional practice evaluation (FPPE) processes, including appropriate resolution of any verified complaints received from patients and/or staff; and
(viii) Additional information specific to Allied Health practitioners.

(b) Additional information specific to Allied Health Practitioners: In addition to consideration of the factors listed in (a), an assessment prepared by the Supervising Physician(s) will be considered as part of the renewal of permission to practice and clinical privileges for Allied Health practitioners.

3.C.3. Practitioner Renewal Application:

(a) The Hospital will follow these procedures to help remind practitioners to submit electronically completed applications in a timely fashion. However, it is the ultimate responsibility of each member to ensure that his or her application is completed on time:

(1) The Credentials Verification Office and Medical Staff Office will maintain a list of all Medical Staff practitioner’s, AHPs and the dates upon which they are due for renewal.

(2) Notification for renewal will be sent electronically by the Credentials Verification Office to practitioners at least four months prior to the expiration of their current term, with a request that the completed renewal application be returned completed electronically, within 60 days.

(3) The Credentials Verification Office and Medical Staff Office will e-mail each practitioner to notify him or her that the renewal application is available electronically (online).

(4) If the Credentials Verification Office has not received a practitioner’s membership renewal application within 60 days of e-mail notification(s) the Medical Staff Office shall call the practitioner to provide a reminder. The Office may leave a message for the member, via voice mail, with office staff, etc., if the practitioner is not personally available to speak. Additionally, practitioners will be notified of their membership/privilege expiration via certified mail prior to expiration.
(5) If the Medical Staff Office has not received a practitioner's complete membership renewal application by the end of the practitioner's current term, the individual's membership, permission to practice, and privileges will expire, and the individual will be required to apply as an initial applicant.

(b) Renewal of membership, permission to practice, and clinical privileges will be for a period of not more than 24 months.

(c) Except as provided below, if an application for renewal is submitted timely, but the Hospital Board has not acted on it prior to the end of the current term, the individual's membership, permission to practice and clinical privileges will expire at the end of the then current term of, subject to hearing and appeals rights under these Bylaws. Subsequent Board action may be to grant renewal of membership or permission to practice and renewal of clinical privileges.

(d) In the event the applicant for renewal is the subject of an investigation or hearing at the time renewal is being considered, a conditional renewal for a period of less than two years may be granted pending the completion of that process.

(e) The application will be reviewed by the Credentials Verification Office and Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for renewal and for the clinical privileges requested.

(f) The Medical Executive Committee will be provided a monthly report of all those physicians/allied health professionals who are in the reappointment process and the progress of the reappointment.

The Medical Staff Office will oversee the process of gathering and verifying relevant information. The Medical Staff Office will also be responsible for confirming that all relevant information has been received.

3.C.4. Processing Applications for Renewal:

(a) The Medical Staff Office will forward the application to the relevant department chairman and the application for membership renewal will be processed in a manner consistent with applications for initial appointment.

(b) If it becomes apparent to the System Credentials Committee or a Hospital MEC that it is considering a recommendation to deny membership renewal or a requested change in staff category, or to reduce clinical privileges, the chairman of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and will be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The committee will indicate as part of its report whether such a meeting occurred and will include a summary of the meeting with its minutes.

3.C.5. Conditional Membership Renewals:

(a) The MEC can recommend and the Board can place conditions on renewal of membership or permission to practice and renewed privileges by requiring an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements).

(b) In addition, renewals may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for renewal for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in these Bylaws.

3.C.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed before the practitioner’s renewal expiration date, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period. If an individual’s timely submitted and timely completed...
application for renewal has not been acted on by the Board within 2 weeks of that individual’s medical staff membership, permission to practice and clinical privileges expiring, the individual shall be entitled to the hearing and appeal rights set forth in these Bylaws shall apply.

ARTICLE 4
CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for Medical Staff membership contained in these Bylaws are eligible to apply for membership to one of the following categories:

4.A. ACTIVE STAFF
4.A.1. Criteria:
The Active Staff shall consist of Members who are involved in 10 or more patient contacts annually.

4.A.2. Prerogatives:
Active Staff Members:
(a) may vote in all general and special meetings of the Medical Staff, and applicable department and committee meetings; and
(b) may hold office, serve as Department Chairmen and serve on committees.

4.A.3. Responsibilities:
(a) Active Staff Members must:
(1) assume all the responsibilities of membership on the Active Medical Staff, including committee service, emergency call and care for unassigned patients as determined by the department and approved by the Medical Executive Committee, and evaluation of Members during the provisional period;
(2) actively participate in the ongoing and focused professional practice evaluation, peer review and performance improvement processes as determined by the Medical Executive Committee;
(3) accept consultations per the department’s rules and regulations;
(4) attend applicable meetings as specified in these bylaws; and;
(5) pay application fees, dues and assessments.
(b) Call shall be mandatory and rotational unless otherwise recommended by a department and approved by the MEC and the Board. Members of the Active Staff who have served on the Active Staff for at least 15 years may request removal from emergency call and other rotational obligations. The clinical specialty section group or the clinical department, as appropriate, shall by simple majority vote recommend to the Medical Executive Committee whether to grant these requests based on need and the effect on others who serve on the call roster for that specialty. The Medical Executive Committee’s recommendation shall be subject to final action by the Board.

4.B. COURTESY STAFF
4.B.1. Qualifications:
The Courtesy Staff shall consist of Members who:
(a) are involved in fewer than 12 patient contacts per membership year; and
(b) hold an active Medical Staff membership at a BayCare Health System Hospital and
(c) at each membership renewal time, provide evidence of clinical performance at their primary Hospital in such form as may be requested. In addition, they shall provide other information as may be required in order to perform an appropriate evaluation of qualifications (including, but not limited to, information from the individual’s office practice, information from managed care organizations in which the individual participates, receipt of confidential evaluation forms completed by referring/referred to physicians, and/or peer evaluations). Involvement in a greater number of patient contacts shall result in automatic transfer to the Active Staff. Patient contacts shall...
be considered any execution of privileges within the hospital including the emergency room.

4.B.2. Prerogatives and Responsibilities:

   Courtesy Staff Members:
   (a) may attend and participate in Medical Staff and department and committee meetings (without vote unless voting rights are specifically granted);
   (b) may not hold office or serve as department chiefs or committee chairpersons;
   (c) are excused from emergency call and care of unassigned patients unless the department so recommends and the Medical Executive Committee finds that there are insufficient Active Staff Members in a particular specialty;
   (d) shall cooperate in the ongoing and focused professional practice evaluation, peer review and performance improvement processes; and
   (e) must pay application fees, dues and assessments.

4.C. CONSULTING STAFF

4.C.1. Qualifications:

The Consulting Staff shall consist of practitioners of recognized professional ability and expertise who provide a service that is not available on the Active Staff, and are appointed to the Active Staff at another hospital where they are currently practicing. At the time of initial membership and at each membership renewal time, they must provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for membership and clinical privileges. In addition, such individuals may be subject to additional focused professional practice evaluation.

4.C.2. Prerogatives and Responsibilities:

Consulting Staff Members:
(a) may treat (but not admit) patients and perform procedures relevant to their specialty, and for which they have been granted clinical privileges, in conjunction with another physician on the Active Staff;
(b) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);
(c) may not hold office or serve as department chairmen or committee chairmen; and
(d) shall pay application fees, dues and assessments.

4.D. HONORARY STAFF

4.D.1. Qualifications:

The Honorary Staff shall consist of member’s who are recognized for outstanding or noteworthy contributions to the Hospital, or have a record of previous long-standing service to the Hospital, and have retired from the active practice of medicine. Upon notification of retirement from active medical practice, the President of the Medical Staff and the MEC will be notified via the Credentials Committee Minutes the requests for changes in staff category assignment. The MEC will review these requests and make a recommendation regarding Honorary staff status assignment to the Hospital Board.

4.D.2. Prerogatives and Responsibilities:

Honorary Staff Members may:
(a) not consult, admit or attend to patients;
(b) attend staff and Department meetings when invited to do so (without vote);
(c) be appointed to committees (with vote);
(d) not vote, hold office, serve as a department chairman; and
(e) not pay application fees, dues or assessments.

4.E. LIMITED STAFF

4.E.1. Criteria:
The Limited Staff shall consist of podiatrist, dentist, and psychologist Members who are involved in 10 or more patient contacts annually.

4.E.2. Prerogatives:
Limited Staff Members:
(a) may be granted clinical privileges
(b) may not vote in meetings of the Medical Staff or departments;
(c) may not hold office, serve as department chairmen, or chair a committee;
(d) may serve as members of committees to which they are appointed.

4.E.3. Responsibilities:
Limited Staff Members must:
(a) assume all the responsibilities of membership on the Medical Staff, including committee service, care for unassigned patients, and focused professional practice evaluation of Members during the provisional period;
(b) actively participate ongoing and focused professional practice evaluation in the peer review and performance improvement processes;
(c) accept consultations per the Hospital's rules and regulations;
(d) serve as members of committees to which they are appointed.

4.F. OUTPATIENT STAFF
4.F.1. Qualifications:
The Outpatient Staff shall consist of Members who:
(a) do not wish to hold inpatient privileges but who otherwise maintain an active medical practice and wish to enjoy the benefits of Medical Staff membership; and
(b) at each membership renewal time, provide evidence of clinical performance at their primary Hospital in such form as may be requested. In addition, they shall provide other information as may be required in order to perform an appropriate evaluation of qualifications (including, but not limited to, information from the individual's office practice, information from managed care organizations in which the individual participates, and receipt of confidential evaluation forms completed by referring/referred physicians, and/or peer evaluations). In addition, such individuals may be subject to additional focused professional practice evaluation.

4.F.2. Prerogatives and Responsibilities:
Outpatient Staff Members:
(a) may attend and participate in Medical Staff and department and committee meetings (without vote unless voting rights are specifically granted as in the case of an elected leadership position);
(b) may not hold office or serve as department chiefs or committee chairpersons;
(c) shall cooperate in the peer review and performance improvement process; and
(d) must pay application fees, dues and assessments.

4.H TELEMEDICINE PRIVILEGES
(a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.
(b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff.
(c) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the President of the Hospital in consultation with the President of the Medical Staff:
   A request for telemedicine privileges be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual
must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in the state where the Hospital is located;
(ii) a current list of privileges granted to the practitioner;
(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;
(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity’s qualifications for the clinical privileges granted;
(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and
(vi) any other attestations or information required by the agreement or requested by the Hospital.

This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(d) Telemedicine privileges, if granted, shall be for a period of not more than two years.
(e) Individuals granted telemedicine privileges shall be subject to the Hospital’s peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
(f) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

ARTICLE 5
CLINICAL PRIVILEGES

5.A. CLINICAL PRIVILEGES
5.A.1. General:
(a) Medical staff membership or the grant of permission to practice will not confer any clinical privileges or right to practice at any of the Morton Plant Mease Health Care Hospitals.
(b) Each Medical Staff member or AHP at a Morton Plant Mease Health Care Hospital is entitled to exercise only those clinical privileges specifically requested by the member and granted by the Board.
(c) Privileges to admit patients to the hospital must be specifically requested and shall be granted only to qualified requestors meeting the clinical criteria for admitting privileges. Admitting privileges shall not be exclusive to hospital employees, members with hospital contracts, or to any single specialty. The grant of clinical privileges includes responsibility for emergency service call established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.
In order for a request for privileges to be processed, the applicant must satisfy eligibility criteria stipulated in these bylaws.

Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts that have been reviewed by the MEC pursuant to Section 5.E.(2).

Clinical privileges will be delineated by core or specialty. A request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual’s primary specialty)

The clinical privileges recommended to the Hospital Board will be based upon consideration of the following:

1. the applicant's education, training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and professionalism with patients, families, and other members of the health care team, peer evaluations relating to these criteria, utilization patterns, and ability to perform the privileges requested competently and safely;
2. availability of qualified staff members or AHPs, as applicable, to provide coverage in case of the applicant's illness or unavailability;
3. adequate professional liability insurance coverage for the clinical privileges requested;
4. the Hospital’s available resources and personnel;
5. information resulting from Ongoing and Focused Professional Practice Evaluation and other performance improvement activities, as applicable;
6. any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
7. any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of membership or clinical privileges at another hospital;
8. practitioner-specific data compared to aggregate data, when available; and
9. morbidity and mortality data, when available.

The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

The report of the chairman of the clinical department(s) in which privileges are sought will be forwarded to the Chairman of the System Credentials Committee and processed as a part of the initial application for staff membership.

During the term of membership, or permission to practice, a practitioner may request increased privileges by applying in writing. The request will state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

5.A.2. Voluntary Relinquishment of Privileges:

(a) No member who provides emergency call or other rotational obligation is eligible to relinquish any privilege within the full core or specialty delineation of privileges considered essential to emergency treatment within their specialty.

(b) In limited circumstances, the Hospital may consider a waiver of the requirement that privileges are granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.

(c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria, as set forth in Section 2.A.2. of these Bylaws.

(d) The following factors, among others, may be considered in deciding whether to grant a waiver:
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(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;
(2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.
(3) the expectations of medical staff Members who rely on the specialty;
(4) fairness to the individual requesting the waiver;
(5) an undue burden to other Members who serve on the call roster in the relevant specialty; and
(6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(e) If the Board grants a waiver related to privileges, it will specify the effective date. In addition, the Board will determine whether the individual granted the waiver must continue to participate in the general on-call schedule for the relevant specialty and maintain sufficient competency to assist the Emergency Medicine physicians in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual will work cooperatively with the Emergency Medicine physician(s) in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(f) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

5.A.3. Clinical Privileges for New Procedures:
(a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Hospital or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established.
(b) The System Credentials Committee will make a preliminary recommendation as to whether the new procedure should be offered, considering whether the Hospital has the capabilities, including support services, to perform the new procedure.
(c) If it is recommended that the new procedure be offered, the System Credentials Committee will refer the procedure to the appropriate department or department(s) to conduct research and consult with experts, including those on the Morton Plant Mease Health Care Medical Staffs and those outside the health care system, and develop recommendations for the MEC regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The System Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The appropriate department or department(s) will forward its recommendations to the applicable Hospital MEC, which will review the matter and forward its recommendations to the Hospital Board for final action.

5.A.4. Clinical Privileges That Cross Specialty Lines:
(a) Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
(b) The System Credentials Committee will conduct research and consult with experts, including those on the Morton Plant Mease Health Care Medical Staffs (e.g., department chairmen, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
(c) The System Credentials Committee will develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The System Credentials Committee will forward its
recommendations to the Hospital MEC, which will review the matter and forward its recommendations to the Hospital Board for final action.

5.A.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:
(a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital will be delineated and recommended in the same manner as other clinical privileges.
(b) Surgical procedures performed by dentists or oral and maxillofacial surgeons will be under the overall supervision of the Hospital's Chairman of Surgery. A medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before dental surgery will be performed (with the exception of (c) below), and a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.
(c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the System Credentials Committee and Hospital MEC.
(d) The dentist or oral and maxillofacial surgeon will be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Staff Bylaws.

5.A.6. New Categories of AHPs:
(a) Determination of Need
(1) Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professional and to make a recommendation to the MEC and the Board. The ad hoc committee shall include the Hospital VPMA, the President of the Medical Staff, and other physician or non-physician members who may be helpful in assessing the services to be provided by the category of Allied Health Professionals in question.
(2) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.
(3) The ad hoc committee may consider the following factors when making a recommendation to the MEC and the Board as to the need for the services of this category of Allied Health Professionals:
   (i) the nature of the services that would be offered;
   (ii) any state license or regulation which outlines the clinical privileges or scope of practice that the Allied Health Professional is authorized by law to perform;
   (iii) any state “non-discrimination” or “any willing provider” laws that would apply to the Allied Health Professional;
   (iv) the business and patient care objectives of the Hospital, including patient convenience;
   (v) the community’s needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional were provided at the Hospital;
   (vi) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
   (vii) the availability of supplies, equipment, and other necessary Hospital resources;
   (viii) the need for, and availability of, trained staff to support the services that would be offered; and
   (ix) the ability to appropriately supervise performance and monitor quality of care.
(b) Development of Policy

(1) If the ad hoc committee determines that there is a need for the particular category of Allied Health Professional at the Hospital, the committee shall recommend to the MEC and the Board a separate policy for these practitioners that addresses:

(i) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(ii) a detailed description of their authorized clinical privileges;

(iii) any specific conditions that apply to their functioning within the Hospital beyond those set forth in this Policy; and

(iv) any supervision requirements, if applicable.

(2) In developing such policies, the ad hoc committee shall consult the appropriate department chair(s) or division chiefs and consider relevant state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

5.A.7. Clinical Privileges for Podiatrists:

(a) The scope and extent of surgical procedures that a podiatrist may perform in the Hospital will be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by podiatrists will be under the overall supervision of the Department of Surgery. For an outpatient procedure a Podiatrist may perform a risk assessment of the procedure and a medical history and physical examination if they are deemed qualified to do so by the System Credentials Committee, MEC and Hospital Board. For all inpatient medical care a medical history and physical examination of each patient will be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery will be performed, and a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Staff Bylaws.

5.A.8. Clinical Privileges for Psychologists:

(a) The scope and extent of any treatment that a psychologist may provide in a Morton Plant Mease Health Care Hospital will be delineated and recommended in the same manner as other clinical privileges.

(b) Medical care provided by psychologists will be under the overall supervision of the applicable Hospital’s Chairman of the Department of Psychiatry. A designated psychiatrist must co-admit any patient admitted by a psychologist, or co-consult any patient consulted by a psychologist, and must assume responsibility for the medical care of the patient throughout the period of hospitalization.

(c) Psychologists may write orders which are within the scope of the clinical privileges that have been granted by the Board, which shall be within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Staff Bylaws.

5.A.9. Physicians in Training:

Physicians in training will not hold Medical Staff membership and will not be granted specific privileges. The program director, clinical faculty, and/or attending staff member of the Hospital will be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital MEC, or its designee, and the Graduate Medical Education Committee. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.
5.B. TEMPORARY CLINICAL PRIVILEGES

5.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the President of Hospital, upon recommendation of the Medical Staff President and Department Chairman, of that Hospital, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

(i) the care of a specific patient;
(ii) an individual serving as a locum tenens for a member of the Medical Staff;
(iii) when necessary to prevent a lack or lapse of services in a needed specialty area;

or

(iv) expansion of privileges by a member of a Morton Plant Mease Healthcare Facility to Mease Countryside Hospital. Prior to the granting of temporary privileges in these situations, current licensure and current competence will be verified.

(b) Temporary privileges may also be granted by the President of the Hospital, upon recommendation of the Medical Staff President and Department Chairman, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Hospital MEC and Hospital Board, following a favorable recommendation of the System Credentials Committee (or its Chairman). Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

(c) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff(s) and Hospital(s).

(d) Temporary privileges will be granted for a specific period of time, as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days. Temporary privileges for an important patient care need may be renewed for an additional period of up to 120 by action of the President of the applicable Hospital in consultation with the Medical Staff President of that Hospital. Individuals serving as locum tenens for a member of the medical staff temporary privileges will not be renewed for longer than 6 months.

(e) Temporary privileges for initial applicants may not be renewed and will expire upon review of the applicant by the Hospital Board.

(f) Temporary privileges will expire at the end of the time period for which they are granted.

(g) Applicants granted temporary privileges will not be eligible to participate in emergency department call rotation unless a specific reason outlined in Section 5.B.1(a) exists.

5.B.2. Supervision Requirements:

In exercising temporary privileges, the individual will act under the supervision of the department chairman. Special requirements of Focused Professional Practice Evaluation, supervision and reporting may be imposed on any individual granted temporary clinical privileges.

5.B.3. Withdrawal of Temporary Clinical Privileges:

(a) The President of the applicable Hospital may, at any time after consulting with the Medical Staff President, the Chairman of the System Credentials Committee, or the applicable department chairman, withdraw temporary admitting privileges. Except as noted below, in the case of withdrawal, the individual’s clinical privileges will expire when the individual’s inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the President of the Hospital, the department
chairman, or the President of the Medical Staff may immediately withdraw all temporary privileges. The department chairman or the President of the Medical Staff will assign to another member of the Medical Staff responsibility for the care of such individual’s patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

(c) The granting of temporary privileges is a courtesy, does not create any expectation of continuation by individual granted temporary privileges, and may be withdrawn for any reason or no reason.

(d) Neither the failure to grant, nor the withdrawal of temporary privileges will entitle the individual to a hearing or appeal.

5.C. EMERGENCY SITUATIONS
(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff with clinical privileges at a Morton Plant Mease Health Care Hospital may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the department chairman or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

5.D. DISASTER PRIVILEGES
(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President of the Hospital or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
   (a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).
   (b) A volunteer's license may be verified in any of the following ways: (a) current Hospital picture ID card that clearly identifies the individual's professional designation; (b) current license to practice; (c) primary source verification of the license; (d) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (e) identification by a current Hospital or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners.

5.E. CONTRACTS FOR SERVICES
From time to time, the hospital may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Hospital. All individuals functioning pursuant to such contracts will obtain and maintain Medical Staff membership, permission to practice, and/or clinical privileges at the Hospital, in accordance with the terms these Bylaws.

Before privileges can be made or continued as exclusive or otherwise limited by operation of a contract or other arrangement between the Hospital and any Practitioner, the Medical Executive Committee shall collect information from the members of medical specialties that would be affected, from the hospital administration, and from other interested parties, in order to make an informed recommendation as to whether quality will be improved or maintained if the privileges are exclusive or otherwise limited through an exclusive contract, and, should such an arrangement be recommended, what contract sources should be utilized. However, the actual terms of any contract and any financial information related to the contract, including but not limited to the remuneration to be paid to medical staff members under contract, are not relevant and therefore shall neither be disclosed to the Medical Executive Committee nor discussed as part of this contracting evaluation process. The MEC shall make a recommendation to the Board.

When awarding, renewing, or terminating an exclusive contract for physician clinical services, a final determination may be made only after a concurrent recommendation of such proposal has been made by the Medical Executive Committee and Board. If the Medical Executive Committee and the Board cannot reach a concurrent recommendation, the issue shall be referred to the Joint Conference Committee.

To the extent that any such contract confers the exclusive right to perform specified services at a Hospital on the other party to the contract, no other person may have clinical privileges to perform the specified services while the contract is in effect.

If any such exclusive contract would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member will be given notice of the exclusive contract and have the right to meet with the Hospital Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected member will be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual will not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her clinical privileges, notwithstanding any other provision of this Policy. The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

A Medical Staff member providing professional services under a contract with the System shall not have Medical Staff membership or privileges terminated for reasons pertaining to the quality of care provided by the Medical Staff member without the same rights of hearing and appeal as are available to all members of the Medical Staff.

ARTICLE 6
PEER REVIEW PROCEDURES

6.A. COLLEGIAL INTERVENTION

Medical Staff leaders shall use progressive steps, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

All collegial intervention efforts by Medical Staff leaders are part of the Hospitals' performance improvement and professional and peer review activities.

The relevant Medical Staff leader(s) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have
an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders.

(6) The President of the Medical Staff, in conjunction with the relevant department chairman or another medical staff officer, CMO/VPMA, will determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Practitioner Health or the Medical Staff Professional Behavior Policy, or to direct it to the MEC for further determination.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

(a) The following are the indications for suspension, reduction, and/or termination of appointment, permission to practice, and clinical privileges if, following the process set forth herein, the issues are not resolved and the MEC makes a recommendation or the Board takes action to suspend, reduce, and/or terminate:

(1) Issues regarding the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients; and/or

(2) The known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Medical Staff.

Whenever a serious question has been raised, or where collegial efforts have not resolved one of these issues, the matter may be referred to the applicable President of the Medical Staff, department chairman, chairman of a standing committee, President of the Hospital, or Chairman of the Board.

(b) The person to whom the matter is referred will make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, will forward it in writing to the Hospital MEC.

(c) No action taken pursuant to this Section will constitute an investigation.

6.B.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Hospital MEC, the MEC will review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another policy, such as the Policy on Practitioner Health or the Code of Conduct Policy, or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation will begin only after a formal determination by the Hospital MEC to do so.

(b) The MEC will inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The President of the Medical Staff will keep the President of the Hospital, the Chair of the System Credentials Committee, and the Medical Staff President of any other Morton Plant Mease Health Care hospital at which the individual holds clinical privileges fully informed of all action taken in connection with an investigation.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the MEC will investigate the matter itself, request that the System Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation. Any ad hoc committee will not include partners, associates, or relatives of the individual being investigated. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist, podiatrist or psychologist).
The committee conducting the investigation ("investigating committee") will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

1. the clinical expertise needed to conduct the review is not available on the Medical Staff; or
2. the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
3. the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated will execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.

The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.

The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it will inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

In making its recommendations, the investigating committee will strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

1. relevant literature and clinical practice guidelines, as appropriate;
2. all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
3. any information or explanations provided by the individual under review.

6.B.4. Recommendation:

(a) The Hospital MEC shall review the report of the investigating committee. It shall accept, modify, or reject any recommendation received from the investigating committee. Specifically, they may:

1. determine that no action is justified;
2. issue a letter of guidance, counsel, warning, or reprimand;
3. impose conditions for continued membership;
(4) impose a requirement for monitoring or consultation;
(5) recommend additional training or education;
(6) recommend reduction of clinical privileges;
(7) recommend suspension of clinical privileges for a term;
(8) recommend revocation of membership and/or clinical privileges; or
(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Hospital MEC that would entitle the individual to request a hearing will be forwarded to the President of the Hospital, who will promptly inform the individual by special notice. The President of the Hospital will hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the Hospital MEC makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Hospital Board.

(d) In the event the Hospital Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the President of the Hospital will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Hospital’s professional practice evaluation, peer review, and performance improvement processes, including pursuant to the applicable policies regarding conduct, as appropriate.

6.C. CONDUCT
6.C.1. Actionable Conduct

Sexual harassment, harassment and other inappropriate personal conduct with the potential to adversely affect patient care are not acceptable to the medical staff and will be corrected, or if correction fails or the conduct warrants, disciplined. Harassment, sexual harassment or other forms of inappropriate personal conduct by a medical staff member or privileges holder, which conduct jeopardizes or could jeopardize quality patient care or the ability of others to provide quality patient care at the hospital, or threatens, or constitutes, harassment against patients, other health care professionals, hospital staff, or individuals on hospital premises will be grounds for corrective action. Verbal, visual or physical abuse directed against patients, other health care professionals, hospital staff, or individuals on hospital premises on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex or sexual orientation will be considered harassment. Failure or refusal of members to cooperate with these conduct procedures, even if the underlying accusation is found to be untrue, will be acted upon as inappropriate conduct.

Members and AHPs are not restricted in advancing medical staff interests and fulfilling duties in good faith or in engaging in competition or pursuit of business interests. Business activities and patient or medical staff advocacy are specifically not to be deemed “disruptive” to the hospital, the system its operations, or mission, and are not actionable under these bylaws.

Actionable conduct by medical staff members or privileges holders, which conduct generates a complaint will be responded to according to these bylaws. Conduct that is actionable but that indicates that the medical staff member suffers from a physical, mental or emotional condition will also be referred to the Health Committee or otherwise evaluated to promote assisting the medical staff member or privileges holder while protecting others.

6.C.2. Corrective Actions for Conduct

Conduct that is not related to a physical condition or other impairment may be managed collegially or may be evaluated for corrective action. Any corrective action will be commensurate with the nature and severity of the unacceptable conduct. Repeated instances of unacceptable conduct will be considered cumulatively and action shall be taken accordingly.

6.C.3. Medical Staff Actionable Conduct Complaint Process
Complaints about a medical staff member’s or privileges holder’s conduct must be in writing, signed and directed to the President of the Medical Staff. The President or designee must review the complaint immediately, and provide the complainant with a written acknowledgement of the complaint and the bylaws or those sections of the bylaws addressing conduct. The President or designee shall make an initial determination of authenticity and severity, and act accordingly. In all cases, the member/privileges holder involved shall be provided with a copy of these bylaws and a description of the general nature of the complaint. Requests by a complainant that "nothing should be done" about an event and that the report is "for information only" cannot be granted. If a complainant wishes to withdraw the report after being so notified, the complainant may do so; but a record of the complaint and the withdrawal shall be retained. Withdrawal of the report will not affect the Medical Executive Committee’s ability to proceed with an investigation or other action pursuant to these bylaws.

At the discretion of the President of the Medical Staff or at the discretion of the Medical Executive Committee, the duties here assigned to the President can be delegated to a different officer of the Medical Staff, on a case-by-case basis or for the President’s term of office.

Complaints will be processed according to the following severity index:
Type I
Physical violence, physical abuse, or threats of physical violence; sexual harassment or harassment involving physical contact; or carrying a gun or other weapon.
In these cases, the President of the Medical Staff shall interview the complainant and, if possible, any witnesses within 24 hours of receiving the complaint. The President and another member of the medical executive committee shall interview the medical staff member within 24 hours.
Type II
Verbal abuse such as unwarranted yelling, swearing or cursing; threatening, humiliating, sexual or otherwise inappropriate comments directed at a person or persons verbally; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or picture(s) directed at a person or person, or violence or abuse directed at an inanimate object. The President of the Medical Staff shall interview the complainant and, if possible, any witnesses within 5 working days of receiving the complaint. The President and another member of the medical executive committee shall interview the medical staff member within 5 working days.
Type III
Abuse or conduct which is directed at-large rather than at any one individual or group of individuals, but has been reasonably perceived by a witness to be inappropriate conduct, as described above; imposing burdensome, idiosyncratic requirements on nursing staff, residents or others, which cannot be reasonably expected to improve patient care. The President shall interview the complainant and, if possible, any witnesses within 10 days of receiving the complaint.

In each case, the President of the Medical Staff shall provide the member the opportunity to respond in writing. The President shall do one or more of the following:
i. determine that no formal action is warranted.
ii. issue a warning and/or otherwise work with the individual collegially to improve upon the areas of concern.
iii. require a written apology to the complainant.
iv. refer member to the Medical Staff Physician Health Committee.
v. initiate corrective action pursuant to the medical staff bylaws.

6.C.4. Conduct Complaints Not Handled By Medical Staff Complaint Process
Inappropriate conduct that violates hospital, but not Medical Staff, policy (e.g. violating the hospital’s no-smoking policy) shall be handled in accordance with the relevant policy.

6.C.5. Abuse of Process
Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who submit a complaint or
complaints which are determined to be false shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.

6.C.6. Conduct Awareness Efforts
The medical staff shall promote continuing awareness of inappropriate conduct issues among the medical staff and the hospital community, including the following efforts:

a) sponsoring or supporting educational programs on inappropriate conduct to be offered to medical staff members and hospital employees;

b) disseminating this Bylaws section to all current members and privileges holders upon its adoption and to all new privileges holders and members of the medical staff upon joining the staff;

c) facilitating assistance by the Medical Staff Physician Health Committee for members of the medical staff and other privileges holders exhibiting inappropriate conduct to obtain education, behavior modification, or other treatment to prevent further violations.

6.D. SUMMARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES
6.D.1. Grounds for Summary Suspension or Restriction:
(a) The President of the Medical Staff or the chairman of a clinical department will each have the authority to suspend or restrict all or any portion of an individual's clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

(b) Summary suspension or restriction can be imposed at any time following a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a summary suspension or restriction, the person(s) considering the suspension will meet with the individual and review the concerns.

(c) Summary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction. Summary suspension is solely to prevent patient harm, and is not to be used to punish past conduct.

(d) A summary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the President of the Hospital and the President of the Medical Staff, and will remain in effect unless it is modified by the President of the Hospital or the Hospital MEC. The summary suspension shall be in effect at all Morton Plant Mease Hospitals at which the physician practices.

(e) Within three days of the imposition of a suspension or restriction, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patients involved, if any.

6.D.2. MEC Procedure:
(a) The Hospital MEC, will review the matter resulting in a summary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC. This meeting is not a hearing under these Bylaws and the individual will not have the right to call and examine or cross-examine witnesses.

(b) The individual may propose ways other than summary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances.

(c) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Hospital MEC will determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Hospital MEC will also determine whether the summary suspension or restriction should
be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(d) If the MEC decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it and a statement that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.

(e) There is no right to a hearing based on the imposition or continuation of a summary suspension or restriction. The procedures outlined above are deemed to be fair under the circumstances.

(f) The imposition or continuation of a summary suspension or restriction is a precaution only and does not constitute a finding of fault on the part of the individual, and, accordingly, shall not be a reportable professional review action and shall not give rise to hearing and appeal rights under these Bylaws.

An investigation should be completed in a timeframe

6.D.3. Care of Patients:
(a) Immediately upon the imposition of a summary suspension or restriction, the President of the Medical Staff will assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the summary restriction, as appropriate. The assignment will be effective until the patients are discharged. The wishes of the patient will be considered in the selection of a covering physician.

(b) All members of the Medical Staff and all AHPs have a duty to cooperate with the President of the Medical Staff, the department chairman, the MEC, and the President of the Hospital in enforcing summary suspensions or restrictions.

6.E. AUTOMATIC RELINQUISHMENT
6.E.1. Failure to Complete Medical Records:
Persistent failure to complete medical records in suitable electronic or paper format in accordance with Hospital policy, the Rules and Regulations and policies of the Medical Staff will result in automatic relinquishment of all hospital clinical privileges, after notification by the medical records department of delinquency and implementation of the progressive steps outlined in the medical staff rules and regulations. Relinquishment shall be in effect at each Morton Plant Mease Health Care facilities at which the individual practices and will continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. While clinical privileges will be relinquished at all Morton Plant Mease Health Care facilities, the reinstatement process will be in accordance with the policies of the facility where the practitioner was deemed delinquent. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations will result in automatic resignation from the Medical Staff or, as applicable, automatic resignation of permission to practice, at each of the Morton Plant Mease Health Care facilities where the individual holds Medical Staff membership, permission to practice, and/or clinical privileges.

6.E.2. Action by Government Agency or Insurer:
(a) Any action taken by any licensing board, professional liability insurance company, court, government agency, or other organization regarding any of the matters set forth below must be promptly reported to the Credentials Verification Office and Medical Staff Office. In addition, an individual must promptly report any loss of, or modification regarding, Board certification.

(b) An individual's membership, permission to practice, and clinical privileges at each Morton Plant Mease Health Care facility will be automatically relinquished if any of the following occur:

1. **Licensure**: Revocation, expiration, or suspension, or the placement of conditions or restrictions on an individual's license.

2. **Controlled Substance Authorization**: Revocation, expiration, or suspension of an individual's DEA controlled substance authorization.
(3) **Insurance Coverage:** Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by these Bylaws or cease to be in effect, in whole or in part.

(4) **Medicare and Medicaid Participation:** Current exclusion, by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) **Criminal Activity:** Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse or neglect of a member of a vulnerable population; or (iv) violence against another.

(c) Automatic relinquishment will take effect immediately upon special notice to the Credentials Verification Office and Medical Staff Office and continue until the matter is resolved, if applicable.

(d) If an individual engages in any patient contact after the occurrence of an event that results in automatic relinquishment, without notifying the Credentials Verification Office and Medical Staff Office of that event, then the relinquishment shall be deemed permanent.

(e) An individual's membership and Clinical Privileges shall be subject to the same conditions or restrictions placed on the member's license or DEA authorization.

(f) Requests for reinstatement or removal of restrictions will be reviewed by the relevant department chairmen, the Chairman of the System Credentials Committee, the Medical Staff President(s) of the applicable Morton Plant Mease Hospital(s), and the President(s) of the Hospital(s). If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at all Morton Plant Mease Health Care Hospitals where he or she has been granted Medical Staff membership and/or clinical privileges. This determination will then be forwarded to the System Credentials Committee, the Hospital MEC(s), and the Hospital Board(s) for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full System Credentials Committee, the Hospital MEC(s), and the Hospital Board(s) for review and recommendation. In either event, if more than one Hospital MEC is involved and they disagree with each other regarding the individual's reinstatement, representatives from the MECs shall meet with the System Credentials Committee to discuss the matter and attempt to resolve the differences. If the MECs are still unable to agree, the matter shall be referred to a Joint subcommittee of the MEC, composed of the Chairman of each relevant MEC which shall resolve the differences and make a recommendation to the MECs.

6.E.3. Failure to Provide Requested Information:
Failure to provide information pertaining to an individual's qualifications for membership or clinical privileges, in response to a written request from the System Credentials Committee, the MEC, or any other committee or Medical Staff or Hospital leader authorized to request such information, or failure to submit to a medical or physical exam, including an alcohol or drug test, as permitted by these Bylaws, will result in automatic relinquishment of all clinical privileges until the information is provided or the matter is resolved, as applicable.

6.E.4. Failure to Attend Special Conference:
(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chairman or the President of the Medical Staff may require the individual to attend a special conference with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference will be given by special notice at least three days prior to the conference and will inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference will be reported to the Hospital MEC. Unless excused by the MEC upon a showing of good cause, such failure will result in
automatic relinquishment of all or such portion of the individual’s clinical privileges as the MEC may direct. Such relinquishment will remain in effect until the matter is resolved.

6.E.5. Action at Another Morton Plant Mease Health Care Facility:
Unless otherwise recommended by the Medical Executive Committee, and Board, due to variation in standards applicable to this Medical Staff or for other cause, any suspension, restriction, limitation, leave of absence, or condition imposed upon an individual at any one Morton Plant Mease Health Care Facility shall automatically and immediately be effective in all Morton Plant Mease Health Care Facility in which the individual has been granted Medical Staff membership, permission to practice, and/or clinical privileges, without recourse to any additional hearing or appeal (as applicable).

6.F. LEAVES OF ABSENCE
(1) A Medical Staff member or AHP at the Hospital may obtain a leave of absence by submitting a written notice to the medical staff office. The request must state the beginning and ending dates of the leave, which cannot exceed one year, and the reasons for the leave. Practitioners must report to the medical staff office any time they are away from medical staff, AHP, and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the President of the Medical Staff, may trigger an automatic leave of absence.

(2) To the extent feasible given the reason for the leave, no leave of absence shall begin until the individual completes all medical records.

(3) During the leave of absence, the individual will not exercise any clinical privileges. In addition, the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

(4) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the medical staff. Requests for reinstatement will then be reviewed by the relevant department chairmen, the Chairman of the System Credentials Committee, the Medical Staff President(s) of the applicable Hospital(s), and the President of the applicable Hospital(s). If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at all Morton Plant Mease Health Care Facilities at which the individual has been granted clinical privileges. This determination will then be forwarded to the System Credentials Committee, the MEC(s) of the applicable Hospital(s), and the Board(s) of the applicable Hospital(s) for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full System Credentials Committee, the MEC(s) of the applicable Hospital(s), and the Board(s) of the applicable Hospital(s) for review and recommendation. In either event, if the MECs of more than one Morton Plant Mease Health Care Facility disagree regarding the reinstatement of an individual, representatives from the MEC(s) shall meet with the System Credentials Committee to discuss the matter and attempt to resolve the differences and make a recommendation to the MECs. If the MECs are still unable to agree, the matter shall be referred to a Subcommittee Committee of the MECs, composed of the Chairman of each relevant MEC, which shall resolve the differences. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

(5) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(6) Absence for longer than one year will result in automatic relinquishment of Medical Staff membership and clinical privileges unless an extension is granted by the President of the Medical Staff. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of patient care at the Hospital.
(7) If an individual’s current membership is due to expire during the leave, the individual must apply for membership renewal; or membership and clinical privileges will lapse at the end of the membership period.

(8) Individuals wishing to resign from the Medical Staff, including relinquishment of all clinical privileges, must provide 30 days’ special notice to the President of the Hospital and Medical Staff Office. The individual must continue to fulfill his or her call responsibilities for the 30 days following such notice. Any subsequent unfulfilled call obligations shall become the responsibility of the remaining members of the department.

ARTICLE 7
HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING
7.A.1. Grounds for Hearing:
(a) Except as otherwise provided in these bylaws, an individual is entitled to request a hearing whenever a Hospital MEC makes one of the following recommendations:
   (1) denial of initial Medical Staff membership;
   (2) denial of Medical Staff membership renewal,
   (3) revocation of Medical Staff membership;
   (4) denial of requested clinical privileges;
   (5) revocation of clinical privileges;
   (6) suspension of clinical privileges for more than 30 days;
   (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
   (8) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
(b) No other MEC recommendations will entitle the individual to a hearing.
(c) If the Board makes any of these recommendations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to "the MEC" will be interpreted as a reference to "the Board."

7.A.2. Actions Not Grounds for Hearing:
None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into his or her file:
(a) issuance of a letter of guidance, counsel, warning, or reprimand;
(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
(c) automatic relinquishment of membership or privileges;
(d) imposition of a requirement for additional training or continuing education;
(e) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;
(f) determination that an application is incomplete;
(g) determination that an application will not be processed due to a misstatement or omission;
(h) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources, or because of an exclusive contract. or;
(i) failure to grant, or withdrawal of, temporary privileges.

7.A.3. Notice of Recommendation:
The President of the applicable Hospital will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:
(a) a statement of the recommendation and the general reasons for it;
(b) a statement that any action taken will be effective at all Morton Plant Mease Health Care Facilities;
(c) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
(d) a copy of this Article.

7.A.4 Request for Hearing:
An individual has 30 days following receipt of the notice to request a hearing. The request will be in writing to the President of the applicable Hospital and will include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.5 Notice of Hearing and Statement of Reasons:
(a) The President of the Hospital will schedule the hearing and provide, by special notice, the following:
   (1) the time, place, and date of the hearing;
   (2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
   (3) the names of the Hearing Panel members and Presiding Officer if known; and
   (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
(b) The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6 Witness List:
(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
(b) The witness list will include a brief summary of the anticipated testimony.
(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.A.7 Hearing Panel, Presiding Officer:
(a) **Hearing Panel:**
The President of the Hospital, based upon the recommendation of the President of the Medical Staff, shall appoint a Hearing Panel in accordance with the following guidelines:
   (1) The Hearing Panel shall consist of at least three members, one of whom shall be designated as Chairman;
   (2) The Hearing Panel shall be selected from members of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel;
   (3) Employment by, or other contractual arrangement with, the Hospital, or an affiliate shall not preclude an individual from serving on the Panel;
   (4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing;
   (5) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing; and
(7) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(b) Presiding Officer:

(1) In lieu of a Hearing Panel Chairman, the President of the Hospital, based upon the recommendation of the President of the Medical Staff, may appoint a Presiding Officer. The Presiding Officer will not act as an advocate for any party in the hearing, or in any previous circumstance, and shall not be in direct economic competition with the individual requesting the hearing.

(2) If no Presiding Officer has been appointed, the Chairman of the Hearing Panel will serve as the Presiding Officer and will be entitled to one vote.

(3) The Presiding Officer will:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence;

(vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but will not be entitled to vote on its recommendations.

(c) Objections:

Any objection to any member of the Hearing Panel, or the Officer, will be made in writing, within 10 days of receipt of notice, to the President of the Hospital. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff will be given a reasonable opportunity to comment. The President of the Hospital will rule on the objection and give notice to the parties. The President of the Hospital may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.8. Counsel:

The Presiding Officer and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state. Any party may be represented by an individual other than an attorney.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;
(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
(4) copies of any other documents relied upon by the MEC.
The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for membership or the relevant clinical privileges will be excluded.

(f) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual will contact Hospital employees, Medical Staff members, or AHPs, whose names appear on the MEC's witness list or in documents provided prior to the hearing concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees, Medical Staff members, or AHPs and confirmed their willingness to meet. Any employee or Medical Staff member or AHP may agree or decline to be interviewed by or on behalf of an individual who has requested a hearing.

7.B.3. Pre-Hearing Conference:
The Presiding Officer will require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.B.4. Stipulations:
The parties and counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.B.5. Provision of Information to the Hearing Panel:
The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) stipulations agreed to by the parties.

7.C. THE HEARING
7.C.1. Failure to Appear:
Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be transmitted to the Board for final action.

7.C.2. Record of Hearing:
A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense.
Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

1. to call and examine witnesses, to the extent they are available and willing to testify;
2. to introduce exhibits;
3. to cross-examine any witness on any matter relevant to the issues;
4. to have representation by counsel who may be present but not call, examine, and cross-examine witnesses and present the case;
5. to submit a written statement at the close of the hearing; and
6. to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) The individual who requested the hearing cannot be forced to testify. However, if the individual fails to testify when questioned by the presiding officer, hearing officer, hearing panel, or the individuals representing the MEC or Board at the hearing, as applicable, the hearing shall immediately stop and the individual shall be deemed to have waived his or her right to a hearing and appeal and to have accepted the recommendation of the MEC and any final action of the Board.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.C.4. Admissibility of Evidence:
The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted 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. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for membership and clinical privileges.

7.C.5. Post-Hearing Statement:
Each party will have the right to submit a written statement, and the Hearing Panel may request that statements be filed, at the close of the hearing.

7.C.6. Persons to be Present:
The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President of the Hospital or the President of the Medical Staff.

7.C.7. Postponements and Extensions:
Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the President of the Hospital on a showing of good cause.

7.C.8. Presence of Hearing Panel Members:
A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she will read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS
7.D.1. Order of Presentation:
The MEC will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.
7.D.2. Basis of Hearing Panel Recommendation:
Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial or renewed membership and clinical privileges, the Hearing Panel will recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.3. Deliberations and Recommendation of the Hearing Panel:
Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a concise statement of the basis for its recommendation.

The Hearing Panel will deliver its report to the President of the Hospital. The President of the Hospital will send by special notice a copy of the report to the individual who requested the hearing. The President of the Hospital will also provide a copy of the report to the MEC.

7.E. APPEAL PROCEDURE
7.E.1. Time for Appeal:
Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President of the Hospital either in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:
The grounds for appeal will be limited to the following:
(a) there was substantial failure by the Hearing Panel to comply with the Bylaws Medical Staff during the hearing, so as to deny a fair hearing; and/or
(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.E.3. Time, Place and Notice:
Whenever an appeal is requested as set forth in the preceding Sections, the Chairman of the Board will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:
(a) The Chairman of the Board will appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.
(b) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
(c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any
opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

(d) The Review Panel will recommend final action to the Board.

7.E.5. Final Decision of the Board:
Within 30 days after receipt of the Review Panel's recommendation, the Board will render a final decision in writing, including specific reasons, and will send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant membership and clinical privileges. A copy will also be provided to the MEC for its information.

7.E.6. Further Review:
Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal will be effective immediately and will not be subject to further review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the Board in accordance with the instructions given by the Board.

7.E.7. Right to One Hearing and One Appeal Only:
No member of the Medical Staff will be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial membership to the Medical Staff or reappointment or revokes the membership and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff membership or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8
CONFLICTS OF INTEREST

(a) When performing a function outlined in the Bylaws or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of President of the Medical Staff (or to the President-Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable Department or Committee Chairman. The President of the Medical Staff or the applicable Department or Committee Chairman will make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that a Department Chairman or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.

(d) The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

(e) Candidates for medical staff officers or committee chairmen, or such medical staff leaders prior to a related decision, shall disclose, prior to election or appointment or discussion of a related decision, that he/she currently receives or imminently or potentially shall receive personal compensation from the Hospital under the terms of a contract or employment; that he/she holds ownership in or directorship or other leadership or employment by a managed care company that contracts with or could contract with the Hospital; or takes or
has taken gifts including goods, services, or honoraria from the Hospital or any company or person who contracts with or otherwise sells to the Hospital.

ARTICLE 9
CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY
Actions taken and recommendations made pursuant to these bylaws will be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities will make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:
(1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee, or authorized agent of the Hospital and are for the purpose of conducting legitimate credentialing and peer review activities;
(2) when the disclosures are authorized by Medical Staff policies or
(3) when the disclosures are authorized, in writing, by the President of the Hospital or by legal counsel to the Hospital.
Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

9.B. PEER REVIEW PROTECTION
(1) All credentialing and peer review activities pursuant to these bylaws will be performed by "Peer Review Committees" in accordance with applicable state law. Peer review committees include, but are not limited to:
(a) all standing and ad hoc Medical Staff and Hospital committees;
(b) hearing panels;
(c) the Board and its committees;
(d) any individual acting for or on behalf of any such entity, including but not limited to department chairmen, committee chairman and members, officers of the Medical Staff, the CMO/VPMA, and experts or consultants retained to assist in peer review activities; and
(e) all departments;
All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law.
(2) All peer review committees will also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. '11101 et seq.

ARTICLE 10
OFFICERS

10.A. DESIGNATION
The officers of the Medical Staff shall be the President, President-Elect, Immediate Past President.

10.B. ELIGIBILITY CRITERIA
Only those Members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:
(1) be Active Staff members in good standing and have served on the Active Staffs for at least five years;
(2) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;
(3) not presently be serving as Medical Staff officers, Board Members or department chairmen at any other hospital and shall not so serve during their terms of office;
(4) be willing to faithfully discharge the duties and responsibilities of the position;
(5) have experience in a leadership position, or other involvement in performance improvement functions for at least two years;
(6) attend continuing education relating to Medical Staff leadership and/or credentialing functions approved by the Medical Executive Committee prior to or during the term of the office;
(7) have demonstrated an ability to work well with others; and
(8) disclose in writing any conflicts consistent with these bylaws

10.C. DUTIES
10.C.1. President of the Medical Staff:
The President of the Medical Staff shall:
(a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;
(b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the Board;
(c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee;
(d) approve all committee chairmen and committee members, in consultation with the Medical Executive Committee;
(e) chair the Medical Executive Committee (with vote, as necessary) and be a member of all other Medical Staff committees, ex officio without vote;
(f) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff;
(g) recommend Medical Staff representatives to Hospital committees, in consultation with the Medical Executive Committee;
(h) perform, or designate other appropriate Medical Staff leaders to perform, all functions authorized in these bylaws and all applicable medical staff rule, regulations, and policies, including collegial intervention and
(i) serve as a member of the Board
(j) oversee the accuracy of the minutes of all medical staff and medical executive committee meetings;

10.C.2. President-Elect:
The President-Elect shall:
(a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her absence;
(b) serve on the Medical Executive Committee;
(c) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the Medical Executive Committee; and
(d) become President of the Medical Staff upon completion of his/her term.
(e) shall be the Chairman or Co-Chairman of the Credentials Committee
(f) account to the medical executive committee and the medical staff for the collection of dues, assessments and fees and disbursement and receipt of all medical staff funds.
(g) attend to all medical staff correspondence unless otherwise delegated under these medical staff bylaws;

10.C.3. Immediate Past President of the Medical Staff:
The Immediate Past President of the Medical Staff shall:
(a) serve on the Medical Executive Committee;
(b) serve as an advisor to other Medical Staff leaders; and
(c) assume all duties assigned by the President of the Medical Staff or the Medical Executive Committee.

10.D. NOMINATIONS
The President of the Medical Staff shall appoint a Nominating Committee consisting of three Members of the Active Staff for all general and special elections. The Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election. Nominations may also be submitted in writing
by petition signed by at least five Active Staff Members at least 10 days prior to the election. In
order for a nomination to be placed on the ballot, the candidate must meet the qualifications stated
in these bylaws, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

10.E. ELECTION
Candidates receiving a majority of written votes cast shall be elected at a meeting of the medical
staff, by mail balloting or by email or web-based balloting, as authorized by the Medical Executive
Committee. If no candidate receives a simple majority vote on the first ballot, a run-off election
shall be held promptly between the two candidates receiving the highest number of votes.

10.F. TERM OF OFFICE
Elected officers of the Medical Staff shall serve for a term of two years or until a successor is
elected.

10.G. REMOVAL
(1) Removal of an elected officer or a member of the Medical Executive Committee may be
effectuated by a two-thirds vote of the remaining members of the Medical Executive
Committee, for:
   (a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
   (b) failure to perform the duties of the position held;
   (c) conduct detrimental to the interests of the Medical Staff, as determined by a two-
       thirds vote of the remaining members of the Medical Executive Committee;
(2) At least 10 days prior to the initiation of any removal action, the individual shall be given
written notice of the date of the meeting at which action is to be considered. The individual
shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote
on removal.
(3) If a Medical Staff officer is employed by the Hospital and his or her employment is
terminated during the term of office, such termination shall not affect the ability of the
officer to serve the remainder of his or her term in office unless, through the employment
contract, the individual has agreed that his or her appointment and privileges will be
coterminous with the contract.

10.H. VACANCIES
A vacancy in the office of President of the Medical Staff shall be filled by the President-Elect, who
shall serve until the end of the President's unexpired term. In the event there is a vacancy in
another office, the Medical Executive Committee shall appoint an individual to fill the office for the
remainder of the term or until a special election can be held, at the discretion of the Medical
Executive Committee.

ARTICLE 11
STAFF DEPARTMENTS

11.A. ORGANIZATION
The Medical Staff shall be organized into the departments as listed in the directory maintained in
the medical staff office.
The Medical Executive Committee, by a two-thirds majority vote, may recommend to the Medical
Staff the creation of new departments, elimination of departments, creation of clinical specialties
within departments, or otherwise the reorganization of department structure. These
recommendations will require approval by a majority of the Medical Staff.

11.B. ASSIGNMENT TO DEPARTMENT
(1) Upon initial membership to the Medical Staff, each member shall be assigned to a clinical
Department. Assignment to a particular Department does not preclude an individual from
seeking and being granted clinical privileges typically associated with another Department.
(2) An individual may request a change in Department assignment to reflect a change in the individual's clinical practice. The MEC shall grant all reasonable requests for change in Department assignment.

11.C. FUNCTIONS OF DEPARTMENTS
The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments; and (ii) to monitor the practice of all those with clinical privileges in a given department. Each department shall determine whether its members will be obligated to serve on call subject to approval by MEC, and provide an emergency call schedule of any department members serving on call.

11.D. QUALIFICATIONS OF DEPARTMENT CHAIRMEN
Each department chairman shall:
(1) be an Active Staff member;
(2) be certified by an appropriate specialty board or be a member presently exempted from this requirement by grandfathering, as determined through the credentialing and privileging process; and
(3) satisfy the eligibility criteria in Section 3.B.

11.E. ELECTION AND REMOVAL OF DEPARTMENT CHAIRMEN
(1) Department chairmen shall be elected by the department. A nominating committee, appointed by the current department chairman, shall nominate qualified candidates. The floor will be opened to nominations. The election shall be by ballot. Ballots may be returned in person, by mail or by facsimile, or by email or web-based balloting as authorized by the Medical Executive Committee. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected. If no candidate receives a majority of the votes cast, the candidate receiving the least number of votes will be eliminated and the vote will be repeated until such time that a majority is achieved. A chairman-elect shall be elected in an identical fashion and shall serve as the vice chairman of the department.
(2) Any department chairman or chairman-elect may be removed by a two-thirds vote of the department Members after reasonable notice and opportunity to be heard. Grounds for removal shall be:
(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
(b) failure to perform the duties of the position held;
(c) conduct detrimental to the interests of the Medical Staff, as determined by a two-thirds majority of the votes submitted; or
(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.
(3) Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the department or Medical Executive Committee prior to a vote on such removal.
(4) Department chairmen and chairman-elect shall serve a term of two years.

11.F. DUTIES OF DEPARTMENT CHAIRMEN
Each department chairman is accountable for the following:
(1) monitoring all clinically related activities of the department;
(2) all administratively related activities of the department, unless otherwise provided for by the Hospital;
(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
(4) recommending to the MEC criteria for clinical privileges that are relevant to the care provided in the department; as well as indicators for ongoing and focused professional practice evaluation that correlate with those privileges;
(5) evaluating requests for clinical privileges for each member of the department;
(6) assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital;
(7) the integration of the department into the primary functions of the Hospital;
(8) the coordination and integration of interdepartmental and intradepartmental services;
(9) the development and implementation of policies and procedures that guide and support the provision of services;
(10) recommendations for a sufficient number of qualified and competent persons to provide medical care, treatment, and service;
(11) determination of the qualifications and competence of Hospital employees, who are not licensed independent practitioners or advanced dependent allied health practitioners, who provide patient care services within the department;
(12) continuous assessment and improvement of the quality of care, treatment, and services provided;
(13) maintenance of quality monitoring programs, as appropriate;
(14) the orientation and continuing education of all persons in the department;
(15) recommendations for space and other resources needed by the department;
(16) performing all functions authorized in these bylaws including collegial intervention; and
(17) oversight of Hospital services used by the department.

11.G. CLINICAL SPECIALTY SECTIONS

11.G.1. Functions of Clinical Specialties Sections:
(a) Clinical specialties may perform any of the following activities:
   (1) continuing education;
   (2) discussion of policy;
   (3) discussion of equipment needs;
   (4) development of recommendations to the department chairman or the Medical Executive Committee;
   (5) participation in the development of criteria for clinical privileges
   (6) discussion of a specific issue at the special request of a department chairman or the Medical Executive Committee; and
   (7) evaluation of related Hospital services and personnel.
(b) No minutes or reports will be required reflecting the activities of clinical specialties, except when a clinical specialty section is making a formal recommendation to a department, department chairman, System Credentials Committee, or Medical Executive Committee.
(c) Clinical Specialties sections shall not be required to hold any number of regularly scheduled meetings.

11.G.2. Qualifications and Election of Clinical Specialty Section Chief:
Clinical specialty section chief shall meet the same qualifications and shall be subject to the same election provisions as department chairmen. Clinical specialty section chiefs shall serve a term of two years or until a successor is elected. In the absence of a candidate for election, a clinical specialty chief shall be appointed by the department chairman.

11.G.3. Duties of Clinical Specialty Section Chief:
The clinical specialty section chief shall carry out the duties requested by the department chairman. These duties may include:
(a) Assist in the review and reporting on applications for initial membership and clinical privileges, including interviewing applicants;
(b) assist in reviewing and reporting on applications for membership renewal and renewal of clinical privileges;
(c) professional practice evaluation of section members during the provisional period;
(d) participation in the development of criteria for clinical privileges and the correlating indicators for ongoing and focus professional practice evaluation;
(e) review and reporting on the professional performance of individuals practicing within the clinical specialty section; and
(f) delegation to a vice chairman such duties as appropriate, including, but not limited to, the review of applications for membership, reappointment, or clinical privileges or questions that may arise if the clinical specialty section Chief has a conflict of interest with the individual under review.

ARTICLE 12
MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

12.A. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The professional practice evaluation and performance improvement functions are the way the Medical Staff works to improve the clinical and non-clinical processes that require Medical Staff leadership or participation. These functions shall be performed by such committees, departments and individuals as may be designated by the Medical Executive Committee in consultation with the President of the Hospital. When the performance of a process is dependent primarily on the activities of individuals with clinical privileges, the Medical Staff shall provide leadership for and participate in process measurement, assessment, and improvement, including, but not limited to:
(a) medical assessment and treatment of patients;
(b) use of medications;
(c) use of blood and blood components;
(d) use of operative and other procedures;
(e) the required content and quality of history and physical examinations, as well as the required time frames for completion;
(f) appropriateness of clinical practice patterns;
(g) significant departures from established patterns of clinical practice;
(h) personnel, equipment, and supplies;
(i) patient safety data; and
(j) the use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process.

(2) Exclusive contracts for clinical services can greatly affect performance improvement, for better or for worse. To promote performance improvement as the goal of exclusive contracts, the medical staff through its Medical Executive Committee, shall be involved in the decision-making surrounding exclusive contracts as described in these bylaws.

12.B. PATIENT CARE PROCESS IMPROVEMENT FUNCTIONS

The Medical Staff shall also participate in the measurement, assessment, and improvement of other patient care processes. These include, though are not limited to:
(1) education of patients and families;
(2) coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient;
(3) accurate, timely, and legible completion of patients' medical records;
(4) sentinel event data;
(5) the use of developed criteria for autopsies;
(6) the Hospital’s and individual practitioners’ performance on Joint Commission and Center for Medicare and Medicaid Services (CMS) core measures;
(7) review of findings of the assessment process that are relevant to an individual’s performance. The medical staff is responsible for determining the use of this information in the ongoing evaluations of practitioners’ competence;
(8) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body; and
(9) assisting with the evaluation of Hospital personnel and the physical plant and recommending improvements thereto.

12.C. APPOINTMENT OF COMMITTEE CHAIRMEN AND MEMBERS
(1) All committee chairmen and members shall be elected based on the criteria set forth in Section 3.B. of these Bylaws.
(2) Committee chairmen and members shall be appointed for initial terms of two years and may be reappointed for additional terms.
(3) The President of the Medical Staff (or respective designees) shall be members, ex officio, without vote, on all committees, unless otherwise stated.

12.D. CREATION OF STANDING COMMITTEES
In addition to the committees established in these bylaws, the Medical Executive Committee may, by resolution and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force shall be performed by the Medical Executive Committee.

Partnership and combined committees may be formed. Unless otherwise specified, these committees will be composed of members from the Medical Staffs of the Morton Plant, Mease Countryside, Mease Dunedin, and Morton Plant North Bay Hospitals, and will function as a single committee acting for all four medical staffs. The chairpersons of the combined committees will be chosen by the Medical Staff Presidents of the involved medical staffs, with the number of chairpersons divided approximately equally between the involved medical staffs. Combined committees will report to the Medical Executive Committees of the involved medical staffs.

12.E. SPECIAL TASK FORCES
Special task forces shall be created and their members and chairmen shall be appointed by the Medical Executive Committee. Such task forces shall confine their activities to the purpose for which they were appointed and shall disband when that purpose has been achieved, unless the Medical Executive Committee continue it or establish it as a standing committee.

12.F. MEDICAL EXECUTIVE COMMITTEE

12.F.1. Composition:
(a) The Medical Executive Committee consists of the officers of the Medical Staff, the elected department chairmen, and the chairman-elect of the Department of Internal Medicine. Members serve ex officio with vote, and accordingly are no longer eligible for membership on the Committee upon leaving office for any reason. Individuals who serve in more than one office are nevertheless entitled to only one vote as an MEC member.
(b) The President of the Medical Staff will chair the Medical Executive Committee.
(c) The CEO/COO may attend meetings of the Medical Executive Committee, without vote.

12.F.2. Duties:
The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws. The Medical Executive Committee is responsible for the following:
(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings subject to the limitations established in these bylaws (the officers are empowered to act in urgent situations between Medical Executive Committee meetings subject to the limitations established in these bylaws). The MEC is accountable to the Medical Staff, and, except for recommendations regarding individual membership, privileges and corrective actions, subject to reversal of its decisions by a majority vote of the Active Staff. Except for corrective action recommendations, it shall make available to the Medical Staff a record of all actions taken, and shall limit annual expenditures to a Medical Staff approved budget. Under no circumstances can the Medical Executive Committee adopt amendments to these
Medical Staff Bylaws or elect Medical Staff officers other than to fill vacancies as provided in these Bylaws.

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff’s structure;
(2) the mechanism used to review credentials and to delineate individual clinical privileges;
(3) recommendations of individuals for Medical Staff membership;
(4) recommendations for delineated clinical privileges for each eligible individual;
(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;
(6) the mechanism by which Medical Staff membership may be terminated;
(7) hearing procedures;
(8) continuing medical education activities;
(9) quality indicators to promote uniformity regarding patient care services;
(10) activities related to patient safety; and
(11) the process of analyzing and improving patient satisfaction.

(c) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate and providing effective liaison among the Medical Staff, Administration, and Board;

(d) reviewing, at least every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable;

(e) providing leadership in activities related to patient safety and the process of analyzing and improving patient satisfaction;

(f) to create, eliminate or combine departments and/or committees consistent with these bylaws;

(g) to overview and manage the Medical Staff professional dues account and, when requested, vote whether to disperse funds for Medical Staff activities;

(h) reviewing the hospital/corporate bylaws, rules and regulations and all pending amendments thereto for any conflicts with the medical staff bylaws, rules and regulations or practices;

(i) consulting with the President of the Hospital on quality-related aspects of contracts for patient care services; and

(j) otherwise enforcing the medical staff bylaws, rules and regulations and policies, by taking action and/or recommending actions to the Board. The Medical Staff can remove the Medical Executive Committee’s delegated authority temporarily, as appropriate to protect the Medical Staff’s interests, by vote of at least two-thirds of the Medical Staff members entitled to vote under these bylaws; and

(k) performing such other functions as are assigned to it by these Bylaws, the rules and regulations or other applicable policies of the medical staff.

12.F.3 MEC Business Updates
In order to fulfill its duties, the Medical Executive Committee shall be kept informed of any hospital decisions that may affect the medical staff organization and its functions. Consequently, any business decisions that affect or may affect the medical staff shall be presented at a meeting of the MEC, as soon as possible but in all cases in advance of their implementation, by hospital management or board members.

12.F.4. Meetings:
The Medical Executive Committee shall meet as often as necessary, normally monthly, but at least six times per year, to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

12.F.5. Voting:
Voting will generally be by a show of hands, but for any vote the MEC will use a secret ballot at the request of any member.
12.G. SYSTEM CREDENTIALS COMMITTEE
12.G.1. Composition:
The System Credentials Committee shall be composed of the President-Elect of the Medical Staffs from each Morton Plant Mease Health Care hospital. Additional members will be selected each year to serve staggered terms of three (3) years. The Presidents-elect of the Medical Staffs will serve for the terms of the offices. Other members may succeed themselves. The members will also elect two Allied Health Professionals to serve on the committee, who will serve as non-voting members of the committee.

The members shall vote to elect one of the Presidents-Elect to serve as the chair. The chair of the System Credentials Committee has the authority to act on the Committee’s behalf in the review and recommendation of all applicants who qualify for temporary privileges in accordance with these bylaws.

12.H. Cancer Committee
A Cancer Committee will be comprised at least one board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology; the cancer liaison physician, and representatives from administration, nursing, social services, the oncology data center, and quality assurance. The cancer registrar will serve as staff to the Committee. The Committee will satisfy the requirements of the Commission on Cancer.

12.I. Medical Staff Health Committee

12.I.1 Composition
The Medical Staff Health Committee shall be comprised of no less than three Active Medical Staff members, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of 3 years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity.

12.I.2 Duties
12.I.2.1. To assist impaired members and thereby further the quality and safety of patient care, the Medical Staff Health Committee may receive reports related to the health, well-being, or perceived impairment of individual medical staff members and, as it deems appropriate, shall evaluate the veracity of such reports, gather additional data and make recommendations regarding such reports. The Committee shall also facilitate self-referral by medical staff members seeking assistance with known or suspected physical, mental or emotional impairment. The Committee may refer the member to appropriate sources of treatment and assistance.

12.I.2.2. With respect to matters involving individual medical staff members, the Committee shall, as may seem appropriate, provide advice, counseling, or monitoring, or coordinate services with outside treatment and assistance sources. Such activities shall be confidential; however, in the event information received by the Committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, or that the member is refusing to obtain assistance or failing to comply with treatment or assistance plans, that information may be referred for corrective action.

12.I.3. Education
The Committee shall also consider general matters related to the health and well-being of the medical staff and hospital staff, and, with the approval of the Medical Executive Committee, develop educational programs on recognizing behavioral problems, illness and impairment in healthcare professionals. The Committee may also develop recommendations for the Medical Executive Committee regarding assisting medical staff members with their health-related problems.

12.I.4. Meetings
The committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis, but at least quarterly, to the Medical Executive Committee.

12. J. JOINT CONFERENCE COMMITTEE

12.J.1. Composition: The Joint Conference Committee shall be composed of an equal number of members of the board and of the medical executive committee, but the medical staff members shall at least include the president of the medical staff, the President-elect of the medical staff, and the immediate past president of the medical staff. The chair of the committee shall alternate between the board and the medical staff for each meeting.

12.J.2. Duties:
The Joint Conference Committee shall meet as needed to discuss issues of interest to both the Medical Staff and Board. Reports of its activities shall be made to the Medical Executive Committee and Board.

ARTICLE 13
CHIEF MEDICAL OFFICER AND VICE PRESIDENTS OF MEDICAL AFFAIRS

13.A. CHIEF MEDICAL OFFICER AND VICE PRESIDENTS OF MEDICAL AFFAIRS
The Chief Medical Officer shall be appointed by the Board upon recommendation of the President of the Hospital and shall be responsible to the President of the Hospital as the chief medical officer of the Hospital. In addition, the Board shall appoint Vice Presidents of Medical Affairs to assist the Chief Medical Officer. The CMO and VPMAs shall be physicians with demonstrated administrative ability. The Chief Medical Officer, in conjunction with the VPMAs, shall perform such duties and functions as may be delegated from time to time by the President of the Hospital, which may include but not be limited to the following:

(1) assisting the President of the Hospital in the implementation of the Hospital's performance improvement program;
(2) serving as an advisor to the Medical Staff and the President of the Medical Staff for proper staff organization and compliance with the medical staff Bylaws;
(3) assisting department chairmen in the performance of their duties;
(4) supervising the operation of the medical library;
(5) actively participating in the preparation and presentation of budgets for each department in conjunction with Hospital management;
(6) acting as the Hospital's medical liaison, after consultation with the President of the Hospital, to local, state and federal agencies;
(7) assisting the President of the Hospital in the supervision and direction of all Hospital-based physicians;
(8) endeavoring to maintain accreditation status and magnet certification;
(9) coordinating all of the medical education activities within the Hospital;
(10) serving as liaison to all academic affiliations of the Hospital; and
(11) assisting the Medical Staff with problem-solving and more efficient medical practice.

No Vice President of Medical Affairs or CMO will serve as a voting member of any medical staff committee, or vote in committee meetings. The Vice President of Medical Affairs’ or CMO’s responsibilities shall not conflict with or usurp the responsibilities of officers or department Chairmen as described in these Bylaws.

13A.1. Confidentiality
Each Vice President of Medical Affairs and CMO will preserve the confidentiality of peer review, credentialing and other data shared with him/her as the work of medical staff committees on behalf of which the Vice President of Medical Affairs and CMO work. Information the Vice President of Medical Affairs and CMO obtain through medical staff committee work will not be shared in a manner which is not protected under state confidentiality and immunity statutes or which would violate the medical staff bylaws, rules and regulations or policy. The Vice President of Medical Affairs and CMO will cooperate with any requests of Medical Staff Officers, Department Directors, and Medical Staff Committee Chairpersons to preserve confidentiality and promote frank discussion of medical staff matters.
13.A.2 Selection
The President of the Hospital shall coordinate any recruiting and hiring efforts involving the position of Vice President of Medical Affairs and CMO with the Medical Executive Committee. The Medical Executive Committee, or a subcommittee thereof designated by the Medical Executive Committee, shall interview all qualified candidates for the position.

ARTICLE 14
MEETINGS

14.A. MEDICAL STAFF YEAR
The Medical Staff year begins with the annual Medical Staff meeting in February and ends with the next annual Medical Staff meeting.

14.B. MEDICAL STAFF MEETINGS
14.B.1. Regular Meetings:
The Medical Staff shall meet at least once a year.

14.B.2. Special Meetings:
Special meetings of the Medical Staff may be called by the President of the Medical Staff, the Medical Executive Committee, the Board, or by a petition signed by not less than ten percent of the Active Staff.

14.C. DEPARTMENT AND COMMITTEE MEETINGS
14.C.1. Regular Meetings:
Except as otherwise provided in these Bylaws, each department and committee shall meet at least semi annually, at times set by the presiding officer.

14.C.2. Special Meetings:
A special meeting of any department or committee may be called by or at the request of the presiding officer, the President of the Medical Staff, or by a petition signed by not less than one-fourth of the Active Staff Members of the department, clinical specialty section, or committee, but not by fewer than two Members.

14.D. PROVISIONS COMMON TO ALL MEETINGS
14.D.1. Notice of Meetings:
(a) Medical Staff Members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments, clinical specialties, and committees at least two weeks in advance of the meetings. Notice will be provided by e-mail and/or facsimile and may also be provided by posting in a designated location at least two weeks prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). Posting may not be the sole mechanism used for providing notice.

14.D.2. Quorum and Voting:
(a) For any regular or special meeting of the Medical Staff, a department, a clinical specialty section, or a committee, those voting Members present shall constitute a quorum. For meetings of the Medical Executive Committee, the presence of at least 50% of voting members shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, clinical specialties, and committees shall be by consensus, unless consensus cannot be reached. In the event it is
necessary to vote on an issue, that issue will be determined by a majority vote of those members of the body present.

(c) The Members of the Medical Staff, a Department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Chairman by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the Chairman by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(d) Notice, attendance, and actions including voting and participation may be accomplished by email or other electronic and/or telephonic means where permitted by the chair of the meeting on either an individual or group basis.

14.D.3. Agenda:
The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, a department, a clinical specialty section, or a committee, but may not bring up new business not already present on the published agenda.

Unless otherwise specified in these bylaws, the medical staff rules and regulations or policy, meetings and other medical staff activities shall be conducted informally, with Robert's Rule of Order serving as a guide. Technical or non-substantive departures from rules shall not invalidate action taken.

14.D.4. Minutes, Reports, and Recommendations:
(a) Minutes of all meetings of the Medical Staff, departments, and committees (and applicable clinical specialty section meetings) shall be prepared and shall include a record of the attendance of Members and the recommendations made and the votes taken on each matter. Names will not be included in the minutes unless necessary for clarification. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, clinical specialties, and committees shall be transmitted to the Medical Executive Committee, President of the Hospital, and VPMA. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments, clinical specialties, and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

14.D.5. Confidentiality:
Members of the Medical Staff who have access to or are the subjects of credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Medical Staff in its bylaws, rules and regulations and policies. A breach of confidentiality may result in the imposition of disciplinary action.

14.D.6. Attendance Requirements:
(a) Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable department, clinical specialty section, and committee meetings each year.

(b) At a minimum, however, each Active Staff member is required to attend at least fifty percent of applicable department and section committee meetings in each year. It is not necessary to prepare excuses for missed meetings because excuses shall not be considered when compliance with this attendance requirement is reviewed.

ARTICLE 15
ALLIED HEALTH PROFESSIONALS

15.A. CONDITIONS OF PRACTICE APPLICABLE TO AHPs
(1) Oversight by Supervising Physician
(a) AHPs may function in the Hospital only so long as they have a Supervising Physician.
(b) Any activities permitted to be performed at the Hospital by an AHP will be performed only under the oversight of the Supervising Physician.
(c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the AHP fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the AHP’s clinical privileges will be automatically relinquished, unless he/she has another Supervising Physician who has been approved as part of the credentialing process.
(d) As a condition of the AHP being granted and/or maintaining clinical privileges, the AHP and/or the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the President of the Hospital and CMO/VPMA within three days of any such change.

(2) Questions Regarding the Authority, Clinical Skill, Judgment, or Professional Conduct of an AHP
(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an AHP to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the AHP. Any act or instruction of the AHP will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges granted to the individual.
(b) Any question regarding the clinical skill or judgment or professional conduct of an AHP will be reported to the President of the Medical Staff, and the CMO/VPMA or the President of the Hospital for appropriate action. The person to whom the matter is reported will handle the matter through the peer review procedures that apply to Medical Staff members and others with clinical privileges, as set forth in Article 6 of these Bylaws. In the case of an AHP, the inquiry or investigation into the matter, and any additional peer review procedures, may include discussions of the matter with the Supervising Physician. AHPs shall be entitled to the same hearing and appeal rights as Medical Staff members, as outlined in Article 7 of these Bylaws.

(3) Responsibilities of Supervising Physicians
(a) Physicians who wish to utilize the services of an AHP in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed and granted clinical privileges in accordance with these Bylaws before the AHP participates in any clinical or direct patient care of any kind in the Hospital.
(b) The number of AHPs acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the Florida medical board and other state agencies regarding the supervision and responsibilities of the AHP, to the extent that such filings are required.
(c) Either the Supervising Physician or AHP will provide, or arrange for, professional liability insurance coverage for the AHP in amounts required by the Board. The insurance must cover any and all activities of the AHP in the Hospital. The Supervising Physician or AHP will furnish evidence of such coverage to the Hospital. The AHP will act in the Hospital only while such coverage is in effect.

ARTICLE 16
HISTORIES & PHYSICAL EXAMINATIONS

(1) To provide optimal continuity of patient care, a documented history and physical must be placed in the medical record within 24 hours of admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia) by an individual who has been granted clinical privileges by the Hospital to perform histories and physicals (physicians, oral and maxillofacial surgeons, or Allied Health Professionals).

(2) A dictated and/or written History/Physical that was performed within the 30 days prior to the
patient’s admission or registration can be used, provided that a copy of it is placed in the record within 24 hours of admission/registration (and prior to surgery or an invasive procedure requiring anesthesia) and the practitioner conducts an update physical examination of the patient within 24 hours of admission/registration (and prior to surgery or an invasive procedure requiring anesthesia) and places a note in the medical record regarding any changes in the patient’s conditions since the date of the original H&P or states that there have been no changes in the patient’s condition.

(3) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient’s chart, with an admission note by the attending physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient’s heart rate, respiratory rate and blood pressure.

(4) A full history and physical examination will include, as pertinent:
   (a) patient identification;
   (b) chief complaint;
   (c) history of present illness;
   (d) review of systems, to include at a minimum:
      (i) cardiovascular;
      (ii) respiratory;
      (iii) gastrointestinal;
      (iv) neuro-musculoskeletal; and
      (v) skin;
   (e) personal medical history, including medications and allergies;
   (f) family medical history;
   (g) social history, including any abuse or neglect;
   (h) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses and, if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder;
   (i) data reviewed;
   (j) assessments, including problem list; and
   (k) a plan of treatment, including, as applicable, any need for restraint or seclusion will be documented in the plan of treatment.

(5) A Short-Form history and physical, containing the chief complaint or reason for the procedure, relevant history of the present illness or injury, and the patient’s present clinical condition/physical findings, may be used for ambulatory or same-day procedures as approved by the Medical Executive Committee.

(6) The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician’s office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

In addition to the requirements set forth in these Bylaws, the History/Physical must also meet the requirements of the Hospital’s policy for documentation in the medical record.
ARTICLE 17
AMENDMENTS

At least 14 days prior to the Executive Committee meeting, members of the Medical Staff shall be notified that copies of all proposed amendments are available on an electronic bulletin board.

(a) Amendments to these Bylaws may be proposed by the Medical Executive Committee, the Bylaws Committee, or by a petition signed by 25% of the voting members of the Medical Staff.

(b) All proposed amendments to these Bylaws must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall provide notice of the proposed amendments including the proposed wording of the amendments, and shall report on the proposed amendments to the voting members of the Medical Staff. The Medical Executive Committee may also report on any proposed amendments at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any General Medical Staff meeting or by voting mechanisms authorized by these bylaws including written or electronic ballot or absentee ballot, if notice has been provided to each voting member at least 30 days prior to the vote. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 50% of the staff eligible to vote.

(c) The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization of the existing provisions, renumbering, or punctuation, spelling or other errors of grammar or expression.

(d) All amendments shall be effective only after approval by the Board, which shall not be unreasonably withheld.

(e) 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. Such a conference will be scheduled by the President of the Hospital within two weeks after receipt of a request for same submitted by the President of the Medical Staff.

(f) Upon adoption and approval of these Bylaws, the hospital and the Medical Staff, intending to comply with the Bylaws, agree that these bylaws shall be binding upon the Medical Staff, its members, the hospital, and upon any successor in interest in this hospital. Affiliations between the hospital and other hospitals, healthcare systems or other entities shall not, of themselves, affect these bylaws.

ARTICLE 18
OTHER MEDICAL STAFF DOCUMENTS

(a) In addition to the Medical Staff Bylaws and internal departmental policies, there shall be policies, procedures and rules and regulations that shall be applicable to all Members of the Medical Staff and other individuals who have been granted clinical privileges (e.g. the credentialing protocols developed for each category of AHP approved by the Board).

(b) Medical Staff documents other than the Medical Staff Bylaws may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists.

(c) Notice of all proposed amendments shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place and any Medical Staff member may submit written comments on the amendments to the Medical Executive Committee.

(d) The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with
the law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 30 days to review and provide to the Medical Executive Committee comments regarding the provisional amendments. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below shall be implemented.

(e) Amendments to Medical Staff policies and rules and regulations may also be proposed by a petition signed by 25% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee which may comment on the amendments before they are forwarded to the Board for its final action.

(f) No amendment shall be effective unless and until it has been approved by the Board.

18.B. CONFLICT MANAGEMENT PROCESS

(a) When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to: (1) proposed amendments to the Medical Staff Rules and Regulations, (2) a new policy proposed by the Medical Executive Committee, or (3) proposed amendments to an existing policy that is under the authority of the Medical Executive Committee, a special meeting of the Medical Staff will be called. The agenda for that meeting will be limited to the amendment or policy at issue. The purpose of the meeting is to resolve the differences that exist with respect to Medical Staff policies and Rules & Regulations.

(b) After opportunity for discussion and exchange of information, members eligible to vote shall determine the position of the Medical Staff by majority vote. Any resulting revision to the amendment or policy shall be forwarded to the Board for its review and approval.

(c) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(d) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to Board will be directed through the President of the Hospital who will forward the request for communication to the Chair of the Board. The President of the Hospital will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board’s response to the Medical Staff member(s).

ARTICLE 19
INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairmen, committee chairmen, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law.

ARTICLE 20
ADOPTION

(a) These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

(b) The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended. To the extent they are inconsistent, the Rules and Regulations are of no force or effect.

(c) The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws, rules and regulations and policies.
Adopted by the Medical Executive Committee on: February 6, 2014.

[Signature]

President of the Medical Staff for Mease Hospitals

Adopted by the Medical Staff on: March 3, 2014.

Approved by the Board on: 3/25/2014.

[Signature]

Chairman, Board of Trustees