MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When a Medical Staff Member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as **Appendix A** to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who:

(a) are involved in at least 24 Patient Contacts per two-year appointment term;

(b) contribute to Medical Staff functions and/or demonstrate a commitment to the Medical Staff and Hospital through service on committees and/or active participation in performance improvement or Professional Practice Evaluation functions; and

(c) at each reappointment time, 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 appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians).

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 Patient Contacts during his or her two-year appointment term shall not be eligible to request Active Staff status at the time of his or her reappointment.

** The member will be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Courtesy, Adjunct, Ambulatory Care, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients consistent with granted Privileges or as stated on the individual's delineation of Privileges, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) vote in all general and special meetings of the Medical Staff and applicable department, section, and committee meetings;

(c) hold office, serve as Department Chairs or Section Chiefs, serve on Medical Staff committees, and serve as chairs of committees; and

(d) exercise such Clinical Privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department in accordance with the Medical Staff's Emergency Department On-Call Policy*;

(c) providing care for Unassigned Patients in accordance with the Medical Staff's Emergency Department On-Call Policy;

(d) participating in the evaluation of new Medical Staff Members;

(e) participating in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties), as may be requested;

(f) accepting inpatient consultations in accordance with the Medical Staff Rules and Regulations;

(g) paying any required application fees and assessments; and

(h) performing assigned duties.

* An Active Staff member may be excused by the MEC from the obligation to provide specialty coverage for the Emergency Department on the recommendation of his/her department in any of the following circumstances:

(i) the member has served at least 20 years on the Medical Staff; or

(ii) the member has reached the age of 55 and has at least five years of service on the Medical Staff.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who*:*

(a) are involved in fewer than 24 Patient Contacts per two-year appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff Members, including specifically those relating to availability and response times with respect to the care of their patients; and

(c) at each reappointment time, 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 appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has no Patient Contacts during his or her two-year appointment term will be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Adjunct, Ambulatory Care, or Coverage).

** Any member who has 24 or more Patient Contacts during his or her two-year appointment term shall be automatically transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff, department, and section meetings (without vote);

(b) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(c) may be invited to serve on committees (with vote);

(d) are generally excused from providing specialty coverage for the Emergency Department for Unassigned Patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department Physician,

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) may be requested to provide specialty coverage if the MEC, in consultation with the applicable Department Chair, finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) may be requested to participate in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) shall exercise such Clinical Privileges as are granted to them; and

(g) shall pay any required application fees and assessments.

2.C. ADJUNCT STAFF

2.C.1. Qualifications:

The Adjunct Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who:

(a) in the discretion of the Credentials Committee, are of demonstrated professional ability and expertise;

(b) provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Adjunct Staff members would not be eligible to request continued Adjunct Staff status at the time of their next reappointments and would have to transfer to a different staff category if they desire continued appointment);

(c) meet the eligibility criteria set forth in the Medical Staff Credentials Policy, with the exception of those pertaining to emergency department call coverage and coverage arrangements. Instead, Adjunct Staff members provide services at the Hospital only at the request of, and in coordination with, other Medical Staff Members who request their services; and

(d) at each reappointment time, 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 appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians).

2.C.2. Prerogatives and Responsibilities:

Adjunct Staff members:

(a) may evaluate and treat patients in conjunction with other Medical Staff Members;

(b) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(c) may attend meetings of the Medical Staff and applicable department and section meetings (without vote);

(d) may be invited to serve on committees (with vote);

(e) are excused from providing specialty coverage for the Emergency Department and providing care for Unassigned Patients;

(f) may be requested to participate in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties); and

(g) shall pay any required application fees and assessments.

2.D. AMBULATORY CARE STAFF

2.D.1. Qualifications:

The Ambulatory Care Staff consists of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists, Psychologists, and any Practitioner who is licensed to practice independently outside of the Hospital who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital and meet the eligibility criteria set forth in the Medical Staff Credentials Policy, with the exception of those pertaining to response times, board certification, emergency department call coverage, coverage arrangements, and eligibility criteria for Clinical Privileges (unless specific Privileges are requested (e.g., to order infusion services)); and

(b) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.D.2.

The primary purpose of the Ambulatory Care Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care. The grant of Ambulatory Care Staff appointment is a courtesy only, which may be terminated by the Board upon recommendation of the MEC, with no right to a hearing or appeal.

2.D.2. Prerogatives and Responsibilities:

Ambulatory Care Staff members:

(a) may attend meetings of the Medical Staff and applicable departments (without vote);

(b) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(c) shall generally have no staff committee responsibilities, but may be invited to serve on committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their relevant outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may not: admit patients, attend patients, exercise Clinical Privileges (unless specific Privileges are requested (e.g., to order infusion services)), write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(k) may refer patients to the Hospital's diagnostic facilities and order such tests;

(l) may be requested to participate in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties); and

(m) must pay any required application fees and assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or coverage group;

(b) at each reappointment time, 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 appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians);

(c) are not required to satisfy any defined response time requirements in place at the Hospital, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and Clinical Privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member who is being covered (i.e., the Active Staff member's own patients or Unassigned Patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for Unassigned Patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff, department, and section meetings (without vote);

(d) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(e) shall generally have no staff committee responsibilities, but may be invited to serve on committees (with vote); and

(f) shall pay any required application fees and assessments.

2.F. EMERITUS STAFF

2.F.1. Qualifications:

(a) The Emeritus Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists, and Psychologists who the MEC believes deserve special recognition based on their contributions to the Medical Staff (e.g., years of service), the community, or to the field of medicine (e.g., developed or pioneered a new therapy or procedure).

(b) Once an individual is appointed to the Emeritus Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application or undergo reappointment processing. However, the Board may terminate such an appointment at any time with no right to a hearing or appeal.

2.F.2. Prerogatives and Responsibilities:

Emeritus Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff, department, and section meetings (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs; and

(f) are not required to pay application fees or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, and Immediate Past Chief of Staff.

3.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, unless a waiver is recommended by the MEC and approved by the Board. They must:

(1) be a Physician (M.D./D.O.) appointed in good standing to the Active Staff;

(2) have no past or pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges;

(3) not presently be serving as a Medical Staff officer, an MEC or Board member, a Department Chair, or a committee chair at any other hospital (excluding LTACHs) and shall not so serve during their term 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;

(6) attend continuing education relating to Medical Staff leadership, credentialing, and/or Professional Practice Evaluation/peer review functions prior to or during the term of the office;

(7) have demonstrated an ability to work well with others; and

(8) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a Medical Staff Member's office and billed under the same provider number used by the Medical Staff Member. The MEC shall assess any such conflicts to determine whether they are such that they render the individual ineligible for the position.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with Hospital Administration 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 CEO and the Board;

(c) serve as an *ex officio* trustee on the Board, with vote;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(e) serve as a voting member and chair the MEC and the Leadership Council;

(f) be a member of all other Medical Staff committees, *ex officio*, without vote;

(g) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(h) perform all functions authorized in all applicable policies, including Collegial Intervention in the Credentials Policy.

3.C.2. Chief of Staff-Elect:

The Chief of Staff-Elect shall:

(a) assume all duties of the Chief of Staff and act with full authority as Chief of Staff when the Chief of Staff is unavailable within a reasonable period of time;

(b) serve as a voting member on the Credentials Committee (as chair), the Leadership Council, and the MEC (as vice chair);

(c) serve as an *ex officio* trustee on the Board, without vote, unless the Chief of Staff is absent, in which case the Chief of Staff-Elect will assume his/her vote;

(d) assume all such additional duties as are assigned to him or her by the Chief of Staff or the MEC; and

(e) become Chief of Staff upon completion of his or her term.

3.C.3. Immediate Past Chief of Staff:

The Immediate Past Chief of Staff shall:

(a) serve as a voting member on the Leadership Council;

(b) serve as a member of the MEC, *ex officio*, without vote;

(c) serve as an advisor to other Medical Staff leaders; and

(d) assume all duties assigned by the Chief of Staff or the MEC.

3.D. NOMINATIONS

The Leadership Council shall convene at least 90 Days prior to the election and shall submit the names of at least one qualified nominee for the office of Chief of Staff-Elect. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 21 Days prior to the election.

3.E. ELECTION

(1) Elections shall be held solely by written and/or electronic ballot returned to the Medical Staff Office in the manner as indicated on the ballot at the time it is distributed. Ballots shall be provided to all members of the Active Staff and completed ballots must be received in the Medical Staff Office by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(2) In the alternative, and in the discretion of the MEC, elections may occur at called meetings of the Medical Staff. Candidates receiving a majority of votes cast at the meeting by those members of the Active Staff present and voting at that meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. 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.

3.F. TERM OF OFFICE

Each officer shall serve a two-year term. The term of office shall commence on the first Day of the Medical Staff year following the election. Each officer shall serve in office until the end his or her term or until a successor is duly elected and has qualified, unless he or she resigns, or is removed from office, or is otherwise unable to complete the term.

At the end of the Chief of Staff's term, the Chief of Staff-Elect shall automatically assume the Chief of Staff office and the Chief of Staff shall automatically serve as the Immediate Past Chief of Staff.

3.G. REMOVAL

(1) Removal of an elected officer may be effectuated by a two-thirds vote of the MEC 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 Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(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 MEC prior to a vote on removal.

3.H. VACANCIES

(1) When a vacancy occurs in the office of the Chief of Staff, the Chief of Staff-Elect shall serve the remaining term of the former Chief of Staff. The vacancy then created in the office of Chief of Staff-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Chief of Staff and Chief of Staff-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions and an election shall be conducted within 90 Days. The Leadership Council shall then convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

(2) When a vacancy occurs in the office of the Chief of Staff-Elect, the MEC shall appoint an interim officer to fill the office until the next regular election, when both a Chief of Staff and Chief of Staff-Elect shall be elected. When a vacancy occurs in the office of the Immediate Past Chief of Staff, the office shall remain vacant until after the next election.

ARTICLE 4

CLINICAL DEPARTMENTS AND SECTIONS

4.A. ORGANIZATION

(1) The Medical Staff shall be organized into departments and sections as determined by the MEC and listed in the Organization Manual.

(2) Subject to the approval of the Board, the MEC may create new departments, eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENTS AND SECTIONS

(1) Upon initial appointment to the Medical Staff, each Medical Staff Member shall be assigned to a clinical department and section, if applicable. Assignment to a particular department or section does not preclude a Medical Staff Member from seeking and being granted Clinical Privileges typically associated with another department.

(2) A Medical Staff Member may request a change in department or section assignment to reflect a change in his or her clinical practice.

(3) Department or section assignment may be transferred at the discretion of the MEC.

4.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; (ii) to monitor the practice of all those with Clinical Privileges in a given department; and (iii) to organize appropriate specialty coverage of the Emergency Department, consistent with the provisions in these Bylaws and related policies.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS AND VICE CHAIRS

Each Department Chair and Vice Chair shall satisfy the following, unless waived by the Board after considering the recommendation of the MEC:

(1) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(2) satisfy the eligibility criteria in Section 3.B.

4.E. APPOINTMENT OF DEPARTMENT CHAIRS AND VICE CHAIRS

(1) DEPARTMENT CHAIRS

(a) Except as otherwise provided by contract, Department Chairs shall be elected by the department, subject to MEC approval and confirmation by the Board. The Leadership Council shall consult with the current Department Chair to identify candidates and confirm the candidates meet the qualifications in Section 3.B (unless waived by the MEC) and are willing to serve.

(b) The chairs of the Departments of Anesthesia, Emergency Medicine, Medicine, OB/GYN, and Psychiatry shall be elected in the month prior to that of the annual meeting of the Medical Staff in odd-numbered years. The chairs of the departments of Diagnostic Services, Pathology, Pediatrics, and Surgery shall be elected in the month prior to that of the annual meeting of the Medical Staff in even-numbered years.

(c) The election shall be by written and/or electronic ballot. Ballots must be returned by the date indicated on the ballot at the time it is distributed. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(e) If no one is willing to serve as a Department Chair, the Leadership Council, in consultation with the MEC, shall appoint an individual to serve.

(f) Elected Department Chairs shall serve a term of two years and may be reelected for two consecutive terms.

(2) VICE CHAIRS

(a) A Vice Chair may be appointed for a specific Department where the CMO and MEC have determined a need for such a position. This decision will be based on factors such as the size of the department and the clinical and administrative demands on the Department Chair.

(b) For Departments where a Vice Chair has been approved, the relevant Department Chair, in consultation with the Leadership Council, shall appoint a Vice Chair, subject to MEC approval and confirmation by the Board.

(c) Vice Chairs shall serve a term of two years and may be reelected for two consecutive terms.

4.F. REMOVAL OF DEPARTMENT CHAIRS AND VICE CHAIR

(1) Any Department Chair or Vice Chair may be removed by a two-thirds vote of the department or by a two-thirds vote of the MEC 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 Hospital and/or its Medical Staff; or

(d) an infirmity that renders the Department Chair or vice Chair incapable of fulfilling the duties of that office.

(2) Prior to the initiation of any removal action, the Department Chair or Vice Chair 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 Department Chair or Vice Chair shall be afforded an opportunity to speak to the department or MEC, as applicable, prior to a vote on such removal being taken.

4.G. DUTIES OF DEPARTMENT CHAIRS

Department Chairs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) 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 criteria for Clinical Privileges that are relevant to the care provided in the department;

(5) evaluating requests for Clinical Privileges for each member of the department;

(6) the integration of the department into the primary functions of the Hospital;

(7) the coordination and integration of interdepartmental and intradepartmental services;

(8) the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

(9) determination of the qualifications and competence of department personnel who are not licensed independent Practitioners and who provide patient care, treatment and services;

(10) recommendations for a sufficient number of qualified and competent persons to provide care or services;

(11) continuous assessment and improvement of the quality of care and services provided;

(12) maintenance of quality monitoring programs, as appropriate;

(13) recommendations for space and other resources needed by the department;

(14) assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital;

(15) the orientation and continuing education of all persons in the department;

(16) evaluation of individuals to assist with Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation;

(17) reviewing and reporting on applications for appointment, reappointment, and Clinical Privileges, and participating in interviews as necessary; and

(18) appointing a Vice Chair, in consultation with the Leadership Council, where the CMO and MEC have determined a need for such a position; and

(19) performing all functions authorized in the Credentials Policy, including Collegial Intervention.

4.H. DUTIES OF DEPARTMENT VICE CHAIIRS

A Vice Chair shall carry out the duties requested by his or her Department Chair. These duties may include, but are not limited to:

(1) assisting with the review of applications for initial appointment, reappointment, and clinical privileges, including interviewing applicants;

(2) evaluation of individuals to assist with Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation;

(3) participation in the development of criteria for clinical privileges;

(4) reviewing and reporting on the professional performance of individuals practicing within the section; and

(5) serving in the absence of the Department Chair.

4.I. CLINICAL SECTIONS

4.I.1. Functions of Sections:

(a) Sections 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 applicable department or the MEC;

(5) participation in the development of criteria for Clinical Privileges (when requested by the Department Chair);

(6) reviewing and reporting on applications for appointment, reappointment, and Clinical Privileges, and participating in interviews as necessary; and

(7) performing all functions authorized in the Credentials Policy, including Collegial Intervention.

(b) No minutes or reports will be required reflecting the activities of sections, except when a section is making a formal recommendation to a department, Department Chair, the Credentials Committee, or the MEC.

(c) Sections shall not be required to hold any number of regularly scheduled meetings.

4.I.2. Qualifications, Selection and Removal of Section Chiefs:

(a) Except as otherwise provided by contract, Section Chiefs will be elected in the same manner as Department Chairs.

(b) Section Chiefs must meet the same qualifications as Department Chairs.

(c) The Department Chair has the authority, subject to consultation with the MEC, to remove a Section Chief from office.

(d) If requested by two-thirds of the Active Staff in a section, the Department Chair will evaluate the performance of a Section Chief to determine whether he or she should be removed from office.

4.I.3. Duties of Section Chiefs:

The Section Chief shall carry out those functions delegated by the department or the MEC, which may include the following:

(a) review and report on applications for initial appointment and Clinical Privileges;

(b) review and report on applications for reappointment and renewal of Clinical Privileges;

(c) evaluate individuals who are granted Privileges in order to confirm competence;

(d) participate in the development of criteria for Clinical Privileges within the section;

(e) review and report regarding the professional performance of individuals practicing within the section; and

(f) support the applicable department in making recommendations regarding the coordination of section activities, as well as the Hospital resources necessary for the section to function effectively.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out OPPE, FPPE, and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Unless otherwise indicated, each committee described in these Bylaws or in the Organization Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated in a specific committee composition, all committee chairs and members shall be appointed by the Leadership Council. Advanced Practice Professionals may be appointed to serve as members of Medical Staff committees. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws, and all committee members must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Organization Manual.

(2) Unless otherwise provided in a specific committee composition, committee chairs and members shall be appointed for an initial term of two years and may serve additional terms. All appointed chairs and members may be removed and vacancies filled by the Leadership Council at its discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO, in consultation with the CMO and/or VPMA, and the Chief of Staff. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Chief of Staff, CMO, VPMA, and the CEO shall be members, *ex officio*, without vote, on all committees.

5.C. MEDICAL EXECUTIVE COMMITTEE

5.C.1. Composition:

(a) The MEC shall consist of the following voting members:

- the Chief of Staff;
- the Chief of Staff-Elect; and
- the Department Chairs.

(b) The Section Chiefs, the Chair of the Advanced Practice Professional Committee, the Chair of the Ethics Committee, the CEO, the Director of THMEP, the Immediate Past Chief of Staff, the CMO, and the VPMA shall serve as *ex officio*, non-voting members.

(c) The Chief of Staff will chair the MEC, while the Chief of Staff-Elect shall serve as vice chair.

(d) Other Medical Staff Members or Hospital personnel may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the MEC.

(e) At the discretion of the Chief of Staff, discussions or meetings of the MEC may be conducted in Executive Session, meaning only the voting members of the committee may attend, along with appropriate Hospital personnel (e.g., the CEO, CMO and/or the VPMA) and any invitees of the Chief of Staff. The conduct and activities of the MEC while in Executive Session shall be consistent with the duties and responsibilities of the committee. In addition, discussions or meetings shall be conducted in a manner consistent with applicable federal and state law, which includes maintaining the strict confidentiality of the proceedings.

5.C.2. Duties:

The MEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff Members with Clinical Privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;

(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) applicants for Medical Staff appointment and reappointment;

(4) delineation of 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 appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with the CEO on quality-related aspects of contracts for patient care services;

(d) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;

(e) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) prioritizing continuing medical education activities;

(i) reviewing, or delegating to a Task Force the responsibility to review, at least once every five years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(j) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, the Board or other applicable policies.

5.C.3. Meetings:

The MEC shall meet a minimum of ten times a year at monthly intervals and shall report the activities of the Medical Staff and the MEC to the Board.

5.D. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(1) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(2) the Hospital's and individual Practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(3) medical assessment and treatment of patients;

(4) the appropriate review and consideration of information received about an adverse privileging determination regarding any Practitioner;

(5) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(6) the utilization of blood and blood components, including review of significant transfusion reactions;

(7) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(8) appropriateness of clinical practice patterns;

(9) significant departures from established patterns of clinical practice;

(10) education of patients and families;

(11) coordination of care, treatment and services with other Practitioners and Hospital personnel;

(12) accurate, timely and legible completion of medical records;

(13) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in **Appendix B** of these Bylaws;

(14) the use of developed criteria for autopsies;

(15) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(16) nosocomial infections and the potential for infection;

(17) unnecessary procedures or treatment; and

(18) appropriate resource utilization.

5.E. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may establish additional committees to perform one or more staff functions and 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 Medical Staff Member, a standing committee, or a special task force shall be performed by the MEC.

5.F. SPECIAL COMMITTEES

Special committees shall be created and their Medical Staff Members and chairs shall be appointed by the Chief of Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet as needed.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the MEC, the Board, or by a petition signed by not less than 10% of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department and committee shall meet as often as necessary to fulfill their responsibilities, at times set by the Presiding Officer.

6.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 Chief of Staff, or by a petition signed by not less than 10% of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.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 and committees at least 14 Days in advance of the meetings. The primary mechanism utilized for providing Notice will be e-mail; however, Notice may also be provided by mail, facsimile, hand delivery, posting in a designated electronic or physical location, or telephone at least 14 Days prior to the meetings. All Notices shall provide 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 and posting may not be the sole mechanism used for providing Notice of a special meeting.

(c) The attendance of any individual Medical Staff Member at any meeting shall constitute a waiver of that individual's objection to the Notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. The only exception to this general rule is for meetings of the MEC, the Professional Practice Committee ("PPC"), and the Leadership Council, where the presence of at least 50% of the voting members of the committee shall constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding, even if attendance drops below the quorum during the course of the meeting.

(c) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(d) When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical Staff or a department or committee, an individual who has recused himself or herself from participation in the vote shall not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the majority vote for that matter would be calculated as five of the remaining nine votes).

(e) The voting Medical Staff Members, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand delivery, website posting, or telephone, or other technology approved by the Chief of Staff, and their votes returned to the Presiding Officer by the method designated in the Notice. Except as noted in (a) above (i.e., meetings of the MEC, the PPC, and the Leadership Council), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(f) At the discretion of the Presiding Officer, one or more Medical Staff Members may participate in a meeting by telephone or video conference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings, and the Presiding Officer (i.e., Chief of Staff, Department Chair, or committee chair, as applicable) shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of Medical Staff Members and the recommendations made and the votes taken on each matter. The minutes shall be signed by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC and to the CEO for purposes of keeping the Board apprised of the activities of the Medical Staff and its departments and committees.

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

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, Medical Staff Members who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, 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 Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC, the PPC, the Leadership Council, and the Credentials Committee is required. All members are required to attend at least

50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is encouraged, but not required, to attend and participate in all Medical Staff meetings and applicable department, section, and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

The Hospital shall indemnify all Practitioners who act for and on behalf of the Hospital in discharging their responsibilities and professional review activities pursuant to these Bylaws, the Credentials Policy, the Medical Staff Organization Manual, the Policy on Advanced Practice and Other Healthcare Professionals, and all associated Professional Practice Evaluation policies of the Medical Staff to the fullest extent permitted by law, in accordance with applicable provisions of the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Advanced Practice and Other Healthcare Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of Clinical Privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the Clinical Privileges requested as set forth in the Credentials Policy and the Policy on Advanced Practice and Other Healthcare Professionals.

8.B. PROCESS FOR PRIVILEGING

Requests for Privileges are provided to the applicable Department Chair/Section Chief, who reviews the individual's education, training, and experience and prepares a form provided by the Medical Staff Office stating whether the individual meets all qualifications. The Credentials Committee then reviews the assessment of the Department Chair/Section Chief, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant Privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable Department Chair/Section Chief, who reviews the individual's education, training, and experience and prepares a form provided by the Medical Staff Office stating whether the individual meets all qualifications. The Credentials Committee then reviews the assessment of the Department Chair/Section Chief, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the

recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.D. DISASTER PRIVILEGING

When the disaster plan has been implemented, the CEO, CMO, VPMA, or Chief of Staff may use a modified credentialing process to grant disaster Privileges after verification of the volunteer's identity and licensure.

8.E. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and Clinical Privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) complete and/or comply with educational or training requirements; or

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted.

(2) Automatic Relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, OR any Medical Staff Officer, Department Chair or Section Chief, acting in conjunction with the CMO, VPMA, or the CEO, is authorized to suspend or restrict all or any portion of an individual's Clinical Privileges as a precaution pending an Investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the MEC or CEO.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 Days.

(5) Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

8.G. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an Investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or Clinical Privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Medical Staff Professionalism Policy or is disruptive to the orderly operation of the Hospital or its Medical Staff.

8.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 Days after the Notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the

Hearing Panel in the form of a post-hearing statement submitted at the close of the hearing.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by the Bylaws Committee, MEC, or by a petition signed by at least 10% of the voting Medical Staff Members.

(2) In the discretion of the MEC, amendments to the Bylaws shall be presented to the Medical Staff in one of the following two ways:

(a) Amendments Subject to Vote via Written and/or Electronic Ballot: The MEC shall present proposed amendments to the Active Staff by written and/or electronic ballot, to be returned by the date and in the manner indicated when the ballot is distributed, which date shall be at least 14 Days after the proposed amendment was provided to the Active Staff. Along with the proposed amendments, the MEC shall provide a report on the amendments either favorably or unfavorably. To be adopted, the amendment must receive a majority of the votes cast by the members of the Active Staff.

(b) Amendments Subject to Vote at a Meeting: In the alternative, the MEC may elect to report on the proposed amendments either favorably or unfavorably 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 meeting if Notice has been provided at least 14 Days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the Active Staff members present at the meeting.

(3) The MEC shall have the power to adopt such clarifications to these Bylaws which are needed because of renumbering, punctuation, spelling or errors of grammar, or change of name(s) or title(s).

(4) All amendments shall be effective only after approval by the Board.

(5) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC 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 CEO within two weeks after receipt of a request for same submitted by the Chief of Staff.

(6) Neither the MEC, the Medical Staff, nor the Board may unilaterally amend these Bylaws.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and Rules and Regulations that shall be applicable to all Medical Staff Members and other individuals who have been granted Clinical Privileges. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These additional documents include, among other policies, the Medical Staff Glossary, the Medical Staff Credentials Policy, the Policy on Advanced Practice and Other Healthcare Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Medical Staff Glossary, the Medical Staff Credentials Policy, the Policy on Advanced Practice and Other Healthcare Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting Medical Staff Member at least 14 Days prior to the MEC meeting when the vote is to take place. Any member of the Active Staff may submit written comments on the amendments to the MEC.

(3) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior Notice is required.

(4) Amendments to the Medical Staff policies and to the Rules and Regulations may also be proposed by a petition signed by at least 20% of the voting Medical Staff Members. Any such proposed amendments will be reviewed by the MEC, which shall report on the proposed amendments either favorably or unfavorably before they are forwarded to the Board for its final action.

(5) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Policy on Advanced Practice and Other Healthcare Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 10% of the Active Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the Active Staff members, to the Board for final action.

(3) 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 Medical Staff Members.

(4) 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 Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Board. Communication from Medical Staff Members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MEC by informing the Chief of 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 10

ADOPTION

These Medical Staff 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.

Adopted by the Medical Staff: _____

Approved by the Board: October 5, 2021

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Adjunct	Ambulatory Care	Coverage	Emeritus
Category Descriptions						
Qualifications	Active attending or specialists within the Hospital who meet minimum activity requirements	Use Hospital for convenience, but if exceed maximum activity requirements, automatic transfer to Active Staff	Demonstrate professional ability and expertise and provide a service not otherwise available or in very limited supply on the Active Staff	Desire to be associated with Hospital, but do not intend to establish a clinical practice and do not exercise any Clinical Privileges	Associated with an Active Staff member(s) at the Hospital and provide coverage support for that member(s)	Deserve special recognition for their contributions to the Medical Staff, the community, or the field of medicine, as recommended by the MEC
Basic Requirements						
Number of patient contacts/2-year	≥ 24	< 24	NA	NA	NA	NA
Rights						
Eligible for admitting Privileges	Y	Y	N	N	Y	N
Eligible for Clinical Privileges	Y	Y	Y	N*	Y	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting Privileges	Y	P	P	P	P	P
Hold office	Y	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver
Responsibilities						
Serve on committees	Y	Y	Y	Y	Y	Y
Meeting requirements	N	N	N	N	N	N
ED call coverage	Y	Y	N	N	Y**	N
OPPE/FPPE	Y	Y**	Y	N	Y	N
Comply with guidelines	Y	Y	Y	NA	Y	NA

Y = Yes
N = No
NA = Not Applicable
P = Partial (with respect to voting, only when appointed to a committee)
* = Unless specific Privileges are requested (e.g., to order infusion services)
** = Only when covering for members of their group practice or coverage group or as otherwise requested

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted Privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness and co-morbidities;
- relevant personal (e.g., allergies and medications, if any), social, and family histories;
- review of systems;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- diagnosis with a plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include, as pertinent: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(4) Obstetrical records must contain prenatal information. The pre-natal record, submitted within 30 Days of the estimated due date, must be a

legible copy of the attending practitioner's office record transferred to the Hospital before admission.

(b) Individuals Who May Perform H&Ps

The following types of Practitioners may generally perform histories and physicals at the Hospital pursuant to appropriately granted Medical Staff appointment or permission to practice and Clinical Privileges:

(1) Physicians;

(2) Dentists, who are responsible for the part of their patients' history and physical examination that relates to Dentistry;

(3) Oral and Maxillofacial Surgeons, who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education, and who have been determined by the Medical Staff to be currently competent to perform a history and physical examination, may be granted the Clinical Privilege to perform the medical history and physical examination;

(4) Podiatrists, who are responsible for the part of their patient's history and physical examination that relates to podiatry;

(5) Psychiatrists, who are responsible for the psychiatric history portion of the record and for requesting a medical history and physical from an appropriate Practitioner;

(6) appropriately privileged Advanced Practice Professionals (subject to any countersignature requirements in the Medical Staff Rules and Regulations);

(7) residents, fellows, interns or medical students who have been granted Practitioner-specific Privileges, or given permission by the Hospital, to perform history and physical examinations, but the H&P must be countersigned by the Physician within 30 Days, with the exception of a preoperative H&P, which must be cosigned before the patient goes to surgery; and

(8) individuals who are not licensed independent practitioners, who may contribute information to be used as part of a patient's medical history and physical examination, under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient's medical history and physical examination.

(c) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 Days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-Day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted Clinical Privileges to complete histories and physicals.

(3) The update of the history and physical examination shall be based on an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition. An interval progress note by the patient's Primary Treating Physician or other responsible Physician may serve as the update.

(4) In the case of readmission of a patient, all previous records will be made available by the Hospital for review and use by the Primary Treating Physician.

(d) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, or radiological procedures with sedation), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the responsible Physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record a history and physical, the responsible Physician will record an admission or progress note immediately following the emergency procedure. The responsible Physician will then document a complete history and physical examination after the emergency situation is resolved.