



MEDICAL STAFF

BYLAWS

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SHANDS JACKSONVILLE MEDICAL STAFF BYLAWS

Bylaws are adopted to provide a structure for self-governance for the organized Medical Staff of the Hospital. The Bylaws provide the framework for the Medical Staff to discharge its responsibility in matters involving the quality of patient care, treatment and services; at all times the Medical Staff shall remain accountable for such to the Board of Directors of Shands Jacksonville Medical Center, Inc. The Bylaws articulate processes for the orderly conduct of Medical Staff functions and resolution of issues.

DEFINITIONS

1. **Advanced Practice Professional or APP:** a licensed healthcare professional who is granted clinical privileges by the Board but is not a member of the Medical Staff.
2. **Board:** the Board of Directors of Shands Jacksonville Medical Center, Inc. Action by the Board can be taken by any duly authorized committee of the Board.
3. **Board Certification:** certification in specialty in which the Practitioner will primarily practice by appropriate specialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Foot and Ankle Surgery, American Board of Maxillofacial Surgery, or the Committee on Dental Accreditation or certification by other recognized specialty certification board deemed satisfactory by Chair of MEC.
4. **Chief Executive Officer or CEO:** the individual occupying the corporate position of Chief Executive Officer of Shands Jacksonville Medical Center, Inc. or in his/her absence, their designee.
5. **Days:** calendar days unless otherwise specified.
6. **Distant Site Telemedicine Entity:** The site from which the prescribing or treating (includes monitoring) physician services are provided. For purposes of this definition in this document, the Hospital is not the Distant Site Telemedicine Entity.
7. **Ex-Officio:** person empowered to act by virtue of the office he/she holds.
8. **Focused Professional Practice Evaluation or FPPE:** Focused Professional Practice Evaluation is a process whereby the Hospital evaluates the privilege-specific competence of the Practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital. This process may also be used when a question arises regarding a Practitioner's ability to provide safe, high quality patient care. Focused Professional Practice Evaluation is a time-limited period during which the Hospital evaluates and determines the Practitioner's professional performance/conduct/competencies.
9. **Hospital:** UF Health Jacksonville, UF Health North, and other hospital-based facilities operated by Shands Jacksonville Medical Center, Inc.
10. **Medical Executive Committee or MEC:** a committee of the Medical Staff described in Article V, Section 2 of the Medical Staff Bylaws.
11. **Medical Record:** Hospital approved repository, electronic or otherwise, used to track and record patient medical information regarding services and treatments provided at the Hospital.
12. **Medical Staff:** the organized structure of medical and osteopathic physicians, dentists, and podiatrists who have met the requirements of the Medical Staff Bylaws and who have received an appointment to the Medical Staff by the Board.

13. **Medical Staff Governing Documents or MSGD:** the Medical Staff Bylaws, the Policy on Clinical Privileges-Advanced Practice Professionals, the Medical Staff Policies, and the Medical Staff Rules and Regulations (if any), as and how such documents may from time to time be promulgated, revised or amended as herein provided. These documents are intended to be read together, with the provisions of the Bylaws enhanced by the particular details contained in other MSGDs. In the event of a conflict between the Bylaws and any other MSGD the Bylaws shall prevail.
14. **Notice:** Unless otherwise specifically provided for in these Bylaws. "Notice" shall mean, and be deemed given when: (a) a written communication is personally delivered to the addressee's business office or home and placed in the hands of the named addressee or his/her assistant or other person in the addressee's office or home who routinely accepts mail on behalf of the addressee, or (b) a written communication is deposited with the U.S. Postal Service (USPS) for any type of delivery service then offered by USPS or other commercial express delivery service, or (c) information addressed to the addressee is transmitted by facsimile or e-mail to the addressee's fax or e-mail address.
15. **Ongoing Professional Practice Evaluation or OPPE:** Ongoing Professional Practice Evaluation is a process whereby the Hospital identifies professional practice trends that may impact quality of care and patient safety which may require formal or informal intervention by the Chief of Service or other Medical Staff leadership, including but not limited to a structured plan for improvement
16. **Physician:** doctor of either medicine or osteopathy who are licensed to practice medicine.
17. **Practitioner:** a licensed physician, dentist, or podiatrist who is a member of the Medical Staff.
18. **Provider:** a healthcare professional who has been granted clinical privileges and who practices in the Hospital pursuant to the Medical Staff Governing Documents.
19. **Professional Review Body:** the Board, the Credentials Committee, the MEC, or any other person, committee, or panel charged with making reports, findings, recommendations, or investigations under the Bylaws and which has the authority to make an adverse recommendation or take an adverse action against a Practitioner or Advanced Practice Professional.
20. **Resident:** physician, dentist, or podiatrist in a post-graduate training program at the Hospital or the University of Florida Health Science Center/*Jacksonville*.
21. **Services:** the organized structure of clinical departments as confirmed by the Board.
22. **UFHSC/J:** the University of Florida Health Science Center/*Jacksonville*.

ARTICLE I. MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws, (expressly including but not limited to the Minimum Required Qualifications in Section 2 below), associated policies, rules and regulations of the Medical Staff and the Hospital.

SECTION 2. MINIMUM REQUIRED QUALIFICATIONS FOR MEMBERSHIP

- A. Minimum Required Qualifications: physicians, dentists, and podiatrists for whom the following can be documented.
1. Current, valid, Florida license or medical faculty certificate/dental faculty teaching permit, or an active duty commission as a medical officer of the United States armed forces while treating military personnel or otherwise acting within the scope of their military responsibilities;
 2. Current, valid federal drug enforcement registration(s) reflecting current, valid address (if required by scope of practice);
 3. Experience, education, training and judgment;
 4. Demonstrated clinical performance and current competence;
 5. Adherence to professional ethics and demonstrated conduct in accordance with the mission and philosophy of the Hospital and the "Medical Staff Code of Conduct";
 6. Safe and effective care of patients in a timely manner;
 7. Effective communication skills;
 8. Work harmoniously with others, so that all patients treated by them will receive quality care, and the Hospital and its Medical Staff will be able to operate in an orderly manner;
 9. Satisfaction of financial responsibility through professional liability insurance, of a type and in an amount established by the Board;
 10. Board Certification as follows:
 - a. At the time of application, the applicant must demonstrate Board Certification by the specialty and/or subspecialty board applicable to the grant of privileges sought, or
 - b. For an applicant who recently completed residency or fellowship program approved by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), Council on Podiatric Medical Education (CPME) or American Dental Association (ADA), in the specialty/subspecialty in which privileges are being sought: the applicant must demonstrate board certification no later than the next regularly scheduled reappointment to the Medical Staff after seven (7) years of initial appointment, or
 - c. The applicant has qualification/experience equivalent to Board Certification by the specialty and/or subspecialty board applicable to the grant of privileges sought as based on recommendation of the Chief of Service.
 - i. The Medical Staff Services Office may only provide an application for membership to a physician who is recommended by the Chief of Service as having equivalent qualification/experience if the grant of membership to the physician would not cause the applicable Service to exceed 10% (rounded down to the nearest whole number) who have not qualified under 10.a. or 10.b. above unless the Service has fewer than 10 members, in which case there may be one such member for the Service.
 - ii. If the Service has reached its 10% threshold, the applicable Chief of Service must provide written documentation to the MEC demonstrating that the physician has equivalent qualifications/experience and either meets a critical care need or possesses unique professional qualifications. The MEC may approve the release of the application to such physician

only if the President of the Medical Staff votes in the majority to approve such release,

or

- d. Practitioners appointed to the Medical Staff prior to September 1, 1999 who were not, at that time, Board Certified are exempt from this requirement, or
- e. Applicants applying for privileges exclusively in general dentistry do not need to hold Board Certification.

Once Board Certification is obtained or Chief of Service determines equivalent qualification/experience it must be continuously maintained.

- 11. Not debarred, excluded or otherwise ineligible for participation in any federally funded health care program;
 - 12. Continuously meet the requirements of a Medical Staff membership category;
 - 13. Seeking privileges to furnish a clinical service that is not included in any exclusive service contract between the Hospital and any group or entity unless the applicant is a member of or employed directly or indirectly by that contracted group or entity (including locum tenens practitioners); and
 - 14. Not denied initial appointment or reappointment, nor had privileges or Medical Staff membership appointment revoked or terminated at Hospital within five (5) years of a pending application for Medical Staff membership at the Hospital.
- B. Only the Board, after consultation with MEC, may grant waivers to the above Minimum Required Qualifications.
 - C. No individual shall be entitled to membership on the Medical Staff or to exercise particular clinical privileges merely by virtue of licensure, certification by or membership in any professional organization, or privileges at any other healthcare organization.

SECTION 3. NON-DISCRIMINATION.

Hospital does not discriminate in granting Staff appointment and/or clinical privileges on the basis of race, religion, color, gender, national origin, disability, age, marital status, sexual orientation, or gender identity.

SECTION 4. RESPONSIBILITIES OF EACH MEMBER

- A. Each Medical Staff member must provide appropriate, timely, and continuous care of his/her patients, which shall be documented in the Hospital Medical Record in a timely manner consistent with Medical Staff Governing Documents.
- B. Each Medical Staff member shall be responsible for the actions of Residents and APPs under his/her supervision, and shall discharge in a responsible and cooperative manner the responsibilities and assignments associated with Medical Staff membership.

- C. Each Medical Staff member must participate, if assigned, in quality/performance improvement activities and in discharging other staff functions as may be required from time to time.
- D. Each Medical Staff member must abide by and comply with the bylaws, policies, procedures, and rules and regulations of the Hospital and the Medical Staff.
- E. Each Medical Staff member must, in accordance with federal and state law and the Hospital's call schedules or upon the reasonable request of the Hospital or its Medical Staff, provide appropriate and necessary emergency medical treatment, within the scope of such Practitioner's privileges, to a patient seeking such treatment, regardless of such patient's ability to pay.
- F. Each Medical Staff member must fulfill obligations identified in the Medical Staff Governing Documents.
- G. Each Medical Staff member must assist the Hospital in the fulfillment of its mission.

SECTION 5. MEDICAL STAFF MEMBER RIGHTS

- A. Any Practitioner shall be given the opportunity to meet with the MEC or designated member representative of MEC regarding a matter of concern to the Practitioner, so long as the Practitioner has first brought the matter to the attention of the Service and/or Division Chief and attempted to resolve the issue of concern with the applicable Service and/or Division, as appropriate. In the event the Practitioner's efforts to resolve the issue within the Service and/or Division are unsuccessful, that Practitioner shall present his/her written request to the Chair of MEC, who, after consultation with the MEC, shall arrange, as appropriate to the issue presented, for the committee to discuss the issue. The written request for the meeting shall identify the matter of concern and summarize efforts to resolve the issue. Written requests received by the Chair of MEC within fourteen (14) days of a regular MEC meeting cannot be considered for that meeting's agenda unless approved by the Chair of MEC.
- B. Any Practitioner may initiate a petition for a general Medical Staff meeting. Upon presentation of a petition identifying the purpose for such meeting and signed by no less than 15% of Active Staff Membership, the MEC will schedule a general staff meeting for the specific purpose identified within the petition. No business other than that topic identified in the petition may be transacted.
- C. This Article does not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges or any other matter relating to an individual Practitioner's Membership or privileging action. The fair hearing procedures in accordance with Article XII provide detailed recourse in these matters.

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE ACTIVE CATEGORY

Qualifications: Appointees to the Active category must be involved in the documented care of at least 25 patients at the Hospital during each twelve (12) month period.

Prerogatives: Appointees to the Active category may:

- A. Exercise such clinical privileges, including admitting privileges, as are granted by the Board.
- B. Vote on all matters presented for a vote to the Medical Staff and/or the service and committee(s) of which the appointee is a member.

Responsibilities: Appointees to the Active Category shall:

- A. Actively participate in the organizational and administrative affairs of the Medical Staff, including but not limited to quality/performance improvement activities; risk management and monitoring activities; voting; committees and other Medical Staff meetings.
- B. Serve on Medical Staff/Service committees as a member and/or chairperson; hold office, as assigned, appointed, or elected in accordance with Medical Staff Governing Documents; and discharge other Medical Staff functions as may be required from time to time.
- C. Care for patients and participate in the on-call coverage of the emergency service and other coverage programs as specified in the Medical Staff Governing Documents.

SECTION 2. THE COURTESY CATEGORY

Qualifications: The Courtesy Category is reserved for Practitioners who do not meet criteria set forth in “Qualifications” in Section 1 of this Article for Active Staff Category, but who occasionally provide services to Hospital patients. Except for dentists, podiatrists, or physicians who hold a regular or part-time clinical appointment with the University of Florida College of Medicine, or other applicable college of the University of Florida, Practitioners in the Courtesy Category must hold an Active Staff appointment with grant of clinical privileges at another local Joint Commission accredited hospital and the Practitioners must have 25 documented patient interactions at the other local Joint Commission accredited hospital.

Prerogatives: Appointees to this category may:

- A. Exercise such clinical privileges, including admitting privileges, as are granted by the Board.
- B. When invited by the Committee Chair or other person calling the meeting, attend meetings of the Medical Staff and Medical Staff committees without voting privileges and attend any Medical Staff or Hospital education programs.

Responsibilities: Appointees to this category must cooperate with quality/performance improvement, risk management, and monitoring activities.

SECTION 3. THE HONORARY CATEGORY

Qualifications: The Honorary Category is restricted to those individuals the Board and Medical Staff wish to honor and whose achievements or outstanding reputation would add distinction to the Medical Staff or individuals who have made outstanding professional contributions to the Hospital. Such staff appointees are not eligible for clinical privileges.

Prerogatives: Appointees to this category may:

- A. Be involved in scholarly and quality improvement activities.

- B. When invited by the Committee Chair or other person calling the meeting, attend meetings of the Medical Staff and Medical Staff committees without voting privileges and attend any Medical Staff or Hospital education programs.

Responsibilities: Appointees to this category shall act in a manner consistent with the Hospital's mission.

ARTICLE III. MEDICAL RECORD DOCUMENTATION/MEDICAL HISTORY AND PHYSICAL EXAMINATIONS

According to Medical Staff and hospital policies, each Practitioner shall be responsible for the timely preparation and completion of the medical and other required records for all patients to whom the Practitioner provides care in the Hospital.

- A. A medical history and physical examination shall be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services or sedation. The medical history and physical examination must be completed and documented by a Practitioner or an Advanced Practice Professional with history and physical examination privileges. All History and Physicals completed by an APP must be countersigned by the admitting Practitioner.
- B. When the medical history and physical examination is completed within 30 days before admission or registration, the Practitioner or APP must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by the Practitioner or APP.
- C. The content of complete and focused history and physical examinations is delineated in Medical Staff Policies.

ARTICLE IV. OFFICER

SECTION 1. OFFICER OF THE MEDICAL STAFF/TERM OF SERVICE

There shall be one officer of the Medical Staff who shall be the Chair of MEC (sometimes referred to as "MEC Chair"). The CEO, in consultation with the Dean of the University of Florida College of Medicine/*Jacksonville*, shall recommend an individual for Board appointment as Chair of MEC. The appointee shall carry the Hospital title of Senior Vice President of Medical Affairs (or equivalent position) and shall serve until removed by the Board, or by either the CEO or the Dean of the University of Florida College of Medicine/*Jacksonville*, after consultation and approval of the Board.

SECTION 2. QUALIFICATIONS

The Chair of MEC must be a member in good standing of the Active Category, have previously actively served on a Medical Staff committee or as a Service Chief, indicate a willingness and ability to serve, and have excellent administrative and communication skills. The Chair of MEC may not simultaneously hold a leadership position with another hospital's medical staff.

SECTION 3. VACANCY

A vacancy in the office of the MEC Chair may occur from time to time, due to temporary or permanent situations which might prevent or deter the MEC Chair from timely performing all functions of the office.

Such situations might include (but are not limited to) the MEC Chair's death, disability, illness, injury, leave of absence, resignation, removal, failure to maintain Active Medical Staff membership or other qualification to be MEC Chair.

- A. When such situation arises, the CEO shall, at the earliest opportunity, make a temporary appointment of the Associate CMO or Assistant CMO as Acting MEC Chair to perform any necessary duties and have the authority of the MEC Chair until the Board can take action as to a permanent appointment or extended temporary appointment based on recommendation and process set forth in Section 1 of this Article, which appointment once made, shall automatically terminate the CEO's temporary appointment.
- B. The CEO shall promptly advise the Board Chair, the MEC, the MEC Chair and the temporary appointee in writing of the temporary appointment. If not already terminated or revoked by Board action, the CEO shall revoke the temporary appointment, and advise the same individuals in writing, once the officer is able, in the opinion of the CEO, to resume full functioning as the MEC Chair.

SECTION 4. DUTIES OF OFFICER

The Chair of MEC shall:

- A. serve as the chief medico-administrative officer of the Hospital;
- B. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- C. appoint the members and chairs of Medical Staff committees, unless otherwise specified in the Medical Staff Governing Documents;
- D. take administrative actions for the MEC, when necessary, between meetings;
- E. be responsible for the application and enforcement of the bylaws, policies, and rules and regulations of the Hospital and its Medical Staff;
- F. be responsible for compliance by the Medical Staff with all requirements of applicable licensure, accreditation, and regulatory agencies dealing with the Hospital;
- G. designate an Active Staff member to act as MEC Chair in the absence of the MEC Chair; and
- H. fulfill such other duties as may be specified in the Medical Staff Governing Documents.

SECTION 5. REMOVAL FROM OFFICE

The Medical Staff may initiate the removal of the Chair of MEC from office by petition of one hundred (100) members of the Active Staff and a subsequent two-third (2/3) affirmative vote by ballot at meeting of the Active Staff; such action shall become effective only after approval by the MEC and the Board. Removal shall be for failure to perform those responsibilities set forth in the Medical Staff Governing Documents; an automatic or summary suspension under Article XII or for conduct that is damaging to the Hospital, its goals, or programs.

ARTICLE V. COMMITTEES

SECTION 1. DESIGNATION AND SUBSTITUTION

All Medical Staff committee members and chairs shall be appointed by the MEC Chair and serve at the pleasure of the MEC Chair. Medical Staff committees not outlined in these Bylaws must be approved by the MEC and their composition and duties shall be stated in Medical Staff Governing Documents.

Activities that call for Medical Staff participation (rather than direct Medical Staff oversight) may be discharged by Medical Staff representation on Hospital committees established to perform such activities.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

Composition: The MEC shall consist of the Hospital's Senior Vice President of Medical Affairs (or equivalent position) who shall serve as Chair of MEC; the Chief of each Service as appointed by Board; three (3) at-large members of the Medical Staff, and the Dean of the University of Florida College of Medicine/*Jacksonville*. Ex-officio members who serve without vote shall be the Chairs of the other standing Medical Staff committees as the MEC Chair shall appoint and invite, and the CEO and his/her designees, the Hospital's Chief Nursing Officer, and other appropriate Hospital employees as invited by the Chair of MEC.

Members-at-Large: Three (3) at-large members shall serve for a term of two (2) years and may succeed themselves for successive terms expiring biennially at the end of the Annual Medical Staff Meeting. Two (2) at-large member shall be appointed by the MEC Chair; one (1) at-large member shall be elected by simple majority vote of the Medical Staff Active membership, based on candidates whose names are provided in writing to the Director of Medical Staff Services no later than fifteen (15) calendar days prior to the Annual Medical Staff Meeting. Candidates for the at-large MEC membership position must be Members of the Active Medical Staff and may self-nominate. The candidate with the most votes shall be elected. In the event of a tie, the MEC Chair shall make appointment from the tying candidates. In the event of a vacancy during a term, the MEC Chair shall appoint a Member of the Active Medical Staff to serve until the next Annual Medical Staff Meeting, when the position shall be filled by vote or appointment as provided herein.

Duties: The duties of the MEC shall be to:

- A. Receive and act upon reports and recommendations from the Medical Staff committees, Services, and other assigned activity groups of the Medical Staff concerning patient care quality and appropriateness reviews, evaluation and monitoring functions, and the discharge of delegated administrative responsibilities, and recommend to the Board specific programs and systems to fulfill these functions;
- B. Receive and act upon reports, if appropriate, from the University of Florida College of Medicine - Jacksonville Graduate Medical Education Committee regarding the safety and quality of patient care, treatment, and services provided by related educational and supervisory needs of Residents participating in graduate medical education programs;
- C. Coordinate the activities of, and implement the policies adopted by Services, Medical Staff, and the Hospital;
- D. Submit recommendations to the Board concerning all matters relating to appointments, reappointments, staff category, and clinical privileges;
- E. Encourage professionally ethical conduct and competent clinical performance on the part of staff appointees, including initiating investigations and initiating corrective action, when appropriate;
- F. Account to the Board and to the staff for overall quality and efficiency of patient care in the Hospital and the participation of the Medical Staff in organization performance improvement activities;

- G. Make recommendations to the Board regarding medico-administrative and Hospital management matters;
- H. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;
- I. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs consistent with the mission of the Hospital;
- J. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by the Medical Staff Governing Documents;
- K. Formulate and/or recommend to the Board Medical Staff rules and regulations, policies and procedures;
- L. Review the Medical Staff Governing Documents and recommend such changes thereto as may be necessary or desirable;
- M. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership may be suspended and/or terminated, and the mechanisms for fair hearing procedures; and,
- N. Undertake any function required to be performed by these Bylaws that are not assigned to a Medical Staff committee.

Meetings: The MEC shall meet as required to perform its assigned functions, but at least quarterly. The Committee shall maintain minutes of meetings.

SECTION 3. PERFORMANCE IMPROVEMENT COMMITTEE

Composition: The membership of the Performance Improvement Committee shall include no fewer than eight (8) representatives of the Active Medical Staff, including at least two (2) members each of the Medicine and Surgery Services. The Committee may also include a Resident and representatives from Hospital administration, including but not limited to nursing services, human resources, and risk management. The chair shall have the authority to invite such additional persons from time to time as are beneficial to address the issues before the Committee.

Duties: The duties of the Performance Improvement Committee shall be to monitor compliance with and enforce the Medical Staff rules and regulations and Medical Staff policies, and to assist the MEC in the performance of its assigned responsibilities. In addition, the Performance Improvement Committee shall:

- A. Ensure that when the performance of a process is dependent primarily on the activities of one or more Provider, the Committee provides leadership for the process measurement, assessment, and improvement. These processes include, but are not limited to:
 - 1. Medical assessment and treatment of patients;
 - 2. Use of medications;
 - 3. Use of blood and blood components;
 - 4. Use of operative and other procedure(s);
 - 5. Efficiency of clinical practice patterns; and
 - 6. Significant departures from established patterns of clinical practice.

- B. Ensure that the Medical Staff participates in the measurement, assessment, and improvement of other patient care processes. The processes include but are not limited to:
 - 1. Education of patients and families;
 - 2. Coordination of care with other Providers and hospital personnel, as relevant to the care of an individual patient; and
 - 3. Accurate, timely, and legible completion of patients' medical records.
- C. Ensure that when the findings of the assessment process are relevant to an individual's performance, the Committee is responsible for determining appropriate use in accordance with standards and regulations.
- D. Ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members.
- E. Ensure that the Medical Staff, with other appropriate hospital staff, develops and uses criteria that identify deaths in which an autopsy should be performed.

Meetings: The Committee shall meet as required to perform its assigned functions, but at least quarterly. The Committee shall maintain minutes of meetings and from time to time report to the MEC on its activities.

SECTION 4. CREDENTIALS COMMITTEE

Composition: The Credentials Committee shall consist of at least eight (8) Active Medical Staff members, and shall have been on the Medical Staff for more than four (4) years. A Practitioner who is serving as a Service Chief shall not be eligible for membership on the Credentials Committee during such time as he/she serves as a Service Chief, unless he/she is a member of the Credentials Committee prior to being appointed as a Chief of Service. The Medical Director of the Transitional Care Unit shall be an ex-officio voting member of the Credentials Committee. Members, including the Chair, shall be appointed by and serve at the pleasure of the MEC Chair and shall have been on the Medical Staff for more than four (4) years. The Chair of the Committee may be chosen from any Service. The remaining members shall be chosen from the following three (3) Service groups, with no fewer than two (2) members appointed from each Service group:

- A. **The Surgical Service Group** will include Medical Staff members from the following services: Surgery, Orthopaedics, Ophthalmology, Obstetrics and Gynecology, Neurosurgery, Maxillofacial Surgery, and Urology.
- B. **The Medical Service Group** will include Medical Staff members from the following services: Medicine, Pediatrics, Family Medicine, Psychiatry, and Neurology.
- C. **The Hospital-based Service Group** will include Medical Staff members from the following services: Radiology, Radiation Oncology, Pathology, Anesthesiology, and Emergency Medicine.

Duties: The duties of the Credentials Committee shall be to:

- A. Review on a continuing basis the process by which applicants seek and receive Medical Staff appointments, reappointments, and grant delineation of clinical privileges pursuant to the Medical Staff Governing Documents and make recommendation to the MEC for modification to these

processes, as necessary or beneficial. The Committee shall also recommend to the MEC criteria to be considered in granting clinical privileges for specific services.

- B. Review and evaluate qualifications and credentials of all applicants for clinical privileges in accordance with the Medical Staff Governing Documents. The Committee shall interview applicants if necessary, and make recommendations to the MEC for action to be taken. Such recommendations may also include Medical Staff membership and category status as applicable. Prior to making its recommendations, the Committee shall consider the applicable Service Chief's evaluation of the applicant.
- C. Assign the Chief of Service or qualified designee the responsibility for completion of any professional competency evaluation.
- D. Make recommendations to the MEC for action to be taken regarding Practitioners who no longer meet any one of the minimum objective criteria for appointment set forth in Article I, Section 2 of these Bylaws.
- E. Recommend delineation of clinical privileges pursuant to the Medical Staff Governing Documents or legal, regulatory, or accreditation requirements.

Meetings: The Credentials Committee shall meet as the Chair deems necessary to discharge its duties, but at least monthly. The Committee shall maintain minutes of the meetings. Service on the Committee shall be considered a primary Medical Staff obligation of each member of the Committee and attendance at meetings is expected.

SECTION 5. ADDITIONAL COMMITTEES

The composition and duties of any other Medical Staff Committees shall be as stated in the Medical Staff Governing Documents and approved by MEC.

ARTICLE VI. SERVICES AND DIVISIONS

The Medical Staff will be organized into Services and Divisions. The Services and Divisions of the Medical Staff and their responsibilities will be stated in Medical Staff Policies.

SECTION 1. QUALIFICATIONS AND SELECTION OF SERVICE CHIEFS

- A. **Qualifications:** Each Service Chief shall be a member in good standing of the Active Medical Staff and shall be Board Certified by an appropriate specialty board or shall have established comparable competency through the credentialing process.
- B. **Selection:** The CEO, in consultation with the Chair of the MEC, shall recommend Service Chiefs to the Board for appointment. Upon approval by the Board, Service Chiefs serve at the pleasure of the Board until replaced by another appointment.
- C. **Removal:** A recommendation for removal of a Service Chief during the term of office may be initiated by the MEC, the Board, or by a two-third (2/3) majority vote of all Active Medical Staff Members of the Service. However, no such removal shall be effective unless and until it has been approved by the Board.

- D. Vacancy: If a vacancy occurs in a Service Chief's position, the MEC Chair shall assume the responsibility of the Service Chief until a Service Chief appointment is made in accordance with Section B of this Section.

SECTION 2. DUTIES OF SERVICES CHIEFS

- A. Account to the Service, MEC and Board for all professional and administrative activities within his/her Service and particularly for the quality and safety of patient care rendered by members of the Service.
- B. Provide for the Ongoing Professional Practice Evaluation, and when appropriate Focused Professional Practice Evaluation of the clinical performance of all Providers exercising clinical privileges within the Service, and make recommendations concerning clinical privileges for each member of the Service as appropriate.
- C. Recommend the criteria for clinical privileges that are relevant to the care provided in the Service.
- D. Provide for the continuing review and investigation of the qualifications and conduct of all Providers seeking or holding privileges in the Service and make recommendations in a timely manner concerning all applications for Medical Staff Membership or clinical privileges within the Service. Recommendations shall be based on criteria which include, but are not limited to, current licensure, relevant training and experience, ability to work in a cooperative and collegial manner with other health care providers, demonstrate current competence, the ability to perform the privileges requested and quality-of-care criteria.
- E. Implement and maintain effective peer review, performance improvement and quality and patient safety activities within the Service, including process measurement and assessment, investigating clinical performance and conducting and initiating any corrective action required.
- F. Be responsible for enforcement within the Service of the Hospital and Medical Staff bylaws, rules and regulations, and policies.
- G. Work with the Hospital administration with regard to all administrative matters, patient care issues, and nursing care issues related to the Service.
- H. Supply references required by other institutions or organizations for credentialing purposes.
- I. Assess and recommend to the MEC or the Board off-site sources for needed patient care, treatment, and services that are not provided by the Service or the Hospital.
- J. Be responsible for the integration of the Service into the primary functions of the Hospital and for the coordination and integration of inter-service and intra-service services.
- K. Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.
- L. When appropriate, make recommendations concerning a sufficient number of qualified and competent persons to provide care, treatment, and services.

- M. Help provide for the orientation and education for all persons in the Service relative to Service issues.
- N. Recommend to the CEO or a designee, space and other resources needed by the Service.
- O. Make recommendations regarding the oversight and maintenance of quality control programs, as appropriate.
- P. Make recommendations to the Credentials Committee, Medical Executive Committee and Hospital administration concerning any proposed new procedures and services, including the training, education and experience required for Providers to exercise privileges for new procedures or services.
- Q. Be responsible for assuming compliance with Hospital regulatory agencies.

ARTICLE VII. RESIDENTS

Residents: It is the policy of the Medical Staff to assist with approved graduate education programs.

Qualifications: Physicians, dentists, and podiatrists in a post-graduate training program sponsored by the Hospital or the University of Florida College of Medicine-Jacksonville (hereinafter referred to as “a Training Program”) shall be referred to in these Medical Staff Bylaws as “Residents”. Residents are not members of the Medical Staff nor do they receive a grant of privileges; accordingly, they are not subject to the Medical Staff credentialing privileges. An individual’s status as a Resident shall commence with the appointment to a Training Program and will conclude with termination from the Training Program.

Responsibilities: Residents shall:

- A. If invited or appointed, serve on or attend Medical Staff committees that pertain to patient safety and quality of patient care, without voting rights.
- B. Provide patient care consistent with assigned duties and Training Program supervision protocols under the supervision of members of the University of Florida faculty with Medical Staff appointment, as more particularly set forth in the “Resident Supervision Guidelines”.
- C. Adhere to the Bylaws, rules and regulation and policies of the Medical Staff and the Hospital, as applicable.
- D. Assist Hospital with the fulfillment of its mission.

Resident Graduate Medical Education Subcommittee of the University of Florida College of Medicine - Jacksonville Graduate Medical Education Committee:

Composition: The Resident Graduate Medical Education Subcommittee shall consist of a peer-selected Resident representative from each accredited residency program. The position of the Chair of the Resident Graduate Medical Education Subcommittee will be determined by a vote of the membership. Appointment will be for the academic year, July 1 - June 30. The Senior Associate Dean for Educational Affairs, University of Florida College of Medicine – Jacksonville, will serve as an ex-officio non-voting member of the Resident Graduate Medical Education Subcommittee.

Participation on the Medical Executive Committee: The Chair of the Resident Graduate Medical Education Subcommittee shall sit on the MEC without a vote and will report to the MEC the activities of the Resident Graduate Medical Education Subcommittee as requested by the MEC Chair. The report shall serve to communicate to the Medical Staff issues regarding patient safety, quality of patient care, and work environment.

ARTICLE VIII. ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals are not eligible for Medical Staff membership; they may provide patient care services consistent with a grant of clinical privileges from the Hospital and their applicable state licensure, certification and as permitted or restricted under Federal and state law.

An Advanced Practice Professional applicant may be awarded a grant of clinical privileges upon approval by the Board following a determination of the applicant's competency based on a review of the applicant's credentials and subsequent recommendations of the applicable Chief of Service, the Credentials Committee and the MEC, as set forth in the Medical Staff Governing Documents.

ARTICLE IX. MEETINGS

The Chair or Acting Chair must be present to call a meeting to order and determine quorum when needed. Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present, is the action of the group. Action may be taken without a physical, in-person meeting by the Medical Staff or Committee by presentation of the question to each member eligible to vote, by mail or electronically, and their vote recorded. Unless otherwise provided for in these Bylaws or the Medical Staff Governing Documents, no vote shall be binding unless the question is voted on by at least the number of voting members of the group that could constitute a quorum.

SECTION 1. QUORUM

Annual Medical Staff Meetings: The presence of thirty (30) Active Medical Staff members shall constitute a quorum.

Medical Executive Committee Meetings: The presence of fifty percent (50%) of the members of the committee eligible to vote shall constitute a quorum.

Credentials Committee Meetings: The presence of one third (1/3) of Committee members eligible to vote shall constitute a quorum.

All Other Medical Staff or Committee Meetings: The Committee Chair shall determine a quorum based on agenda items to be presented at the meeting with the minimum being at least two (2) members of the committee eligible to vote.

SECTION 2. MEDICAL STAFF MEETINGS

- A. An annual meeting of the Medical Staff shall be held. Notice of the meeting shall be sent to the Active Medical Staff members no less than fourteen (14) days before date of the meeting.
- B. The Chair of MEC may call a special meeting of the Medical Staff at any time. The Chair of the MEC shall call a special meeting within thirty (30) days after receipt of a written request, signed by no less than 15% of the Active Medical Staff or upon a resolution by the MEC. Such request or resolution shall state the purpose of the meeting, and the Chair of MEC shall designate the time

and place of any special meeting. Notice stating the time, place, and purpose of any special meeting of the Medical Staff shall be sent to Active members of the Medical Staff, as appropriate to the topic of the meeting, at least fourteen (14) days before the date of such meeting, except as provided in Section 5 for emergency special meetings. No business shall be transacted at any special meeting other than as identified in the Notice of such meeting.

SECTION 3. COMMITTEE MEETINGS

- A. Committees may, by resolution, provide the time for holding regular meetings, which shall remain viable unless superseded by specific resolution or action of the Chair.
- B. A special meeting of any committee may be called by, or at the request of, the committee Chair or by the MEC Chair.

SECTION 4. ATTENDANCE REQUIREMENTS

Medical Executive and Credentials Committee Meetings: Members of the Medical Executive Committee and Credentials Committee are expected to attend at least 50% of the meetings held annually.

Medical Staff Meetings: All members of the Active Medical Staff are expected to attend the Annual Medical Staff meeting and other committee and Medical Staff meetings.

SECTION 5. NOTICE OF MEETINGS

Notice stating the date, time, and location of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee not less than seven (7) days before such meeting by the person or persons calling the meeting. If an emergency special meeting is deemed necessary by the MEC Chair or other appropriate chair, such emergency special meeting may be held upon two (2) day written or verbal notice or conspicuous posting. The attendance of a member at the meeting shall constitute a waiver of Notice of such meeting.

SECTION 6. ACTION AT MEETINGS

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee unless otherwise stated in Medical Staff Governing Documents. Such recommendation will then be forwarded to the MEC for action as appropriate.

SECTION 7. MINUTES

Minutes of committee meetings shall be made, recording the attendance of members and other persons present, and the result of each matter presented for a vote. The Chair or person presiding over the meeting shall sign the minutes. Each committee shall maintain minutes of committee meetings.

SECTION 8. PARTICIPATION BY HOSPITAL CHIEF EXECUTIVE OFFICER

The CEO or his/her designee may attend any committee meeting of the Medical Staff.

ARTICLE X. HOSPITAL INDEMNIFICATION OF MEDICAL STAFF MEMBERS

The Hospital will defend and indemnify a Medical Staff member for claims arising out of his/her good faith performance of his/her duties as a member of a Medical Staff committee or his/her participation in Medical Staff or Hospital peer review and/or quality assurance/improvement activities.

ARTICLE XI. APPOINTMENT AND CLINICAL PRIVILEGES

PART A: CONDITIONS AND DURATION

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in or admit patients to the Hospital. Each individual who has been given an appointment to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board, subject to the Hospital's right to contractually arrange with a group or entity for the exclusive furnishing of certain services at the Hospital.

The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated current competence and ability to perform those privileges requested, the ability to assure qualified medical coverage in the Practitioner's absence, the availability of Hospital resources and personnel to support the privileges requested, and other relevant information. The applicant shall have the burden of establishing her/his qualifications for and competence to exercise the clinical privileges requested.

Only those individuals who have requested and been granted admitting privileges may admit patients to inpatient services; however, the Hospital has the right to coordinate attending physician coverage for unassigned patients in the emergency department through an on-call schedule, contract or agreement with Practitioners or Practitioner groups or entities, by other means needed to arrange such coverage or any combination of such means.

- A. The Board shall make initial appointments and reappointments to the appropriate Medical Staff category. The Board shall act on appointments and reappointments only after there has been a recommendation from the MEC.
- B. Appointments and reappointments to the Medical Staff shall be for no more than three (3) years and may be shorter.

PART B: APPLICATION PROCESS

SECTION 1. APPLICATION

- A. An application for appointment, reappointment, clinical privileges, or change in Medical Staff category or status ("application") shall be submitted in writing and shall include detailed information concerning the applicant's professional qualifications.
- B. A preliminary screening process shall be implemented to ascertain whether an applicant meets the Minimum Required Qualifications as set forth in the Medical Staff Bylaws in Article I, Section 2 or the APP clinical privilege policy. Only individuals whose application appears to meet such requirements shall have their applications reviewed by the Medical Staff Services Office for completeness. A member of the Medical Staff Services Department will conduct the preliminary screening process to avoid the costly and time-consuming application process where an applicant fails to meet threshold qualifications.
- C. Until all information and documents requested have been provided and verified for accuracy, no application shall be deemed complete and accepted for processing as set forth in Section 3 herein below.

SECTION 2. UNDERTAKINGS

The following undertakings shall be applicable to every applicant as a condition of consideration of such application for appointment/reappointment and/or clinical privileges; and as a condition of continued Medical Staff appointment and/or clinical privileges:

- A. An agreement to be bound by all policies, procedures, bylaws and rules and regulations of the Hospital and Medical Staff.
- B. An acknowledgement that the applicant has the burden of producing adequate information for a proper evaluation of the applicant's competence, character, ethics, health status and other qualifications and for resolving any questions about such qualifications.
- C. An agreement to appear for an interview, if requested, and acknowledgement that failure to produce requested information or appear for a requested interview will prevent the application from being evaluated and acted upon.
- D. An agreement to undergo a physical (including but not limited to drug and alcohol testing) and/or mental health examination, testing or evaluation relative to the applicant's ability to perform privileges requested or held, or fulfill any obligation of Medical Staff membership at any time, at the request of the Credentials Committee, Chief of Service, MEC Chair or the Board. A brief statement of reason shall support such request.
- E. An attestation that the information in the application is true, complete and correct, and an agreement to notify the Hospital in writing within thirty days of any change or addition to the information provided by the applicant.
- F. An acknowledgement that as a condition of making an application, any misrepresentation, misstatement, or omission may constitute cause for automatic and immediate rejection of the application, including acknowledgement that, in the event that approval has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in immediate termination from the Medical Staff and/or clinical privileges.
- G. A pledge to provide or arrange for the provision of continuous quality patient care for the applicant's patients if granted appointment and/or clinical privileges.

Each applicant shall specifically agree to these undertakings as part of the Application.

SECTION 3. BURDEN OF PROVIDING INFORMATION

A. The applicant shall have the burden of providing adequate information for a proper evaluation of the applicant's competence, character, ethics, and other qualifications, and of resolving any questions about such qualifications raised at any time during the application review process. Additional information may be requested by any Service Chief, or by the Credentials Committee or the Medical Executive Committee or the Board. The applicant shall have the burden of providing evidence that all statements made and information given on the Application are true and correct.

B. An application is not considered complete until all information requested by the Hospital has been received, including: an application form with all required responses provided; verification of all necessary information; adequate responses from references; and any additional or subsequently requested information

deemed necessary and appropriate. It is the responsibility of the applicant to ensure that the Application is complete.

C. An application once deemed complete may thereafter be deemed incomplete if at any time during the consideration of the application new, additional, or clarifying information is requested. An incomplete application will not be processed, or further processed if questions arise at any time prior to appointment, until all requested information is received.

D. If any information cannot be obtained or verified or is not supplied by the applicant upon request by the applicant, the applicant shall be notified in writing that if the required information or verification satisfactory to the Hospital is not received from the applicant within sixty (60) calendar days after such request, the Application shall be deemed withdrawn, unless the time to obtain the information is extended by the Chair of the Credentials Committee,

Should information provided in the application change at any time, including after appointment or grant of clinical privileges is made, the individual shall have the obligation to provide written notice of such change and sufficient information about such change for the Credentials Committee's review and assessment.

SECTION 4. AUTHORIZATION AND RELEASE

The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges in the Hospital. By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of the applicant's application, whether or not the applicant is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment and/or clinical privileges.

- A. **Authorization to Obtain Information:** The applicant shall specifically authorize the Hospital to inspect all records and documents that may be material to evaluating the applicant's professional qualifications and competence and to carry out the clinical privileges requested, as well as the applicant's moral and ethical qualifications. The applicant shall specifically authorize the Hospital and its authorized representatives to consult with any individual(s) and/or entities who may have information, including, but not limited to, otherwise privileged or confidential information, bearing on the professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on the satisfaction of the criteria for appointment and/or granting of clinical privileges.
- B. **Immunity:** The applicant shall specifically agree to release from any and all liability, to the fullest extent permitted by law, all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment/reappointment and/or clinical privileges, including otherwise privileged and confidential information, as regards the application and/or continued appointment.
- C. **Authorization to Release Information:** The applicant shall, if requested, specifically authorize the Hospital to release information to managed care organizations with which the Hospital may become affiliated and release the Hospital from any and all liability for providing information concerning the applicant's competence, ethics, character, and other qualifications for staff appointment/reappointment and/or clinical privileges, including otherwise privileged and confidential information, so long as such release of information is given without malice and in good faith.

The applicant shall authorize the Hospital to disclose and make available to any hospital/facility/program to which the applicant has made or makes application, all information contained in the application and/or obtained as a result thereof.

PART C: PROCESSING APPLICATIONS

SECTION 1. CHIEF OF SERVICE

After receiving references, verifications and all other information or materials deemed pertinent, the Medical Staff Services Office shall transmit the application and all supporting materials for evaluation by the Chief of Service (based on clinical privileges sought). Within thirty (30) days of receipt of a complete application, the Chief of Service shall provide the Credentials Committee with a recommendation regarding the experience, training, competence staff category of the applicant, relative to the clinical privileges requested. If the Chief of Service does not make a recommendation within thirty (30) days, the application will be forwarded to the Credentials Committee with no recommendation.

SECTION 2. CREDENTIALS COMMITTEE

The Credentials Committee shall review the application, the supporting documentation, recommendations, evidence of adherence to accepted professional ethical standards and behavior and current competency to perform requested privileges, and such other information available that may be relevant to consideration of the applicant's qualifications for the staff category and/or clinical privileges requested. The Credentials Committee shall then forward a report of its recommendations to the MEC for action. The recommendation shall include any special conditions of the grant of privileges.

SECTION 3. RECOMMENDATION OF MEDICAL EXECUTIVE COMMITTEE

- A. After considering the report from the Credentials Committee, the MEC shall recommend action upon each application and/or request for privileges. If a recommendation is favorable to the applicant, the recommendation shall be forwarded to the Board for final action. All recommendations to approve appointment and/or grant privileges must also recommend the specific privileges to be granted.
- B. If an adverse recommendation is made, either with respect to appointment or the scope of privileges, the reason for such recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the MEC, all of which shall be forwarded to the CEO or a designee. The CEO or a designee shall promptly provide the applicant Notice of the proposed adverse recommendation and of the applicant's right to a hearing, if any, in accordance with the applicable Fair Hearing procedure(s) as contained in these Bylaws and other Medical Staff Governing Documents.
- C. If the applicant waives the right to a hearing or does not have such right pursuant to Article XIII, the CEO shall forward the MEC's recommendation with supporting documentation to the Board for final action. If the applicant exercises the right to a hearing, the MEC may reconsider its adverse recommendation after receiving the Hearing Panel report and recommendation. The MEC shall forward its final recommendation to the Board for final action.

SECTION 4: DEFERRAL

When the recommendation of the Credentials Committee or the MEC is to defer the application for further consideration, the applicant shall be given notice of the reason for deferral. The Committee shall make a subsequent recommendation within one hundred (100) days of the notice.

SECTION 5: BOARD APPROVAL

The Board has final responsibility for approval or disapproval of all applications for membership, continued membership, and/or clinical privileges. Notice of the Board's decision shall be sent to the applicant. In the event the Board considers modification of an action of the MEC that did not entitle the applicant to a hearing, and such Board modification would entitle the applicant to a hearing, the applicant shall be notified by the CEO, and no final action thereon shall be taken by the Board until the individual has exercised or waived the right to a hearing and appeal all as provided herein under Article XIII.

SECTION 6: TIME FOR FINAL ACTION

Once received from the Chief of Service, an application must be acted upon by the Credentials Committee and presented to the Board by the MEC within one hundred (100) days, unless the process has been delayed by a hearing, deferred, or unless this requirement is otherwise waived by the Board for good cause.

PART D: CLINICAL PRIVILEGES

Requests for a grant of clinical privileges and/or appointment or reappointment to the Medical Staff shall be processed pursuant to the basic steps outlined in these Bylaws herein at Article XI and associated detail described in the Medical Staff Governing Documents.

SECTION 1. CHANGE TO CLINICAL PRIVILEGES

Whenever an individual desires a change to additional clinical privileges, such person shall make the request in writing, stating in detail the specific modification sought and the appointee's relevant recent training and experience that justify such modification. The request shall be processed in the same manner as an application for initial clinical privileges.

SECTION 2. TEMPORARY CLINICAL PRIVILEGES

Upon the recommendation of a Chief of Service, and the concurrence of the MEC Chair, the CEO may, at her/his sole discretion, grant temporary privileges to a physician, podiatrist, dentist or advance practice professional for a specified period of time not to exceed 120 days. For the purposes of any rights and responsibilities set forth in the Medical Staff Bylaws, the recipient of the grant of temporary privileges is not a member of the Medical Staff.

SECTION 3. DISASTER PRIVILEGES

Disaster privileges are granted only when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs. The CEO may designate one of the following individuals to grant disaster privileges subsequent to review of the physician's file and determine that the physician meets the present, important patient care needs:

- A. Medical Care Director
- B. Medical Staff Director
- C. Operation Chief

The above individual's job duties are defined in the Hospital Incident Command System (HICS) manual.

SECTION 4. TELEMEDICINE PRIVILEGES

Healthcare professionals who provide healthcare services to the Hospital's patients through a telemedicine link or modality must do so under a grant of privileges from the Hospital if these services include patient care and treatment, as evidenced by making clinical evaluations or medical decisions that impact the care and/or treatment of the patient; A grant of privileges is not necessary to merely provide a second opinion, so long as no entries are to be made in the patient's medical record at the Hospital.

An applicant for telemedicine privileges shall be credentialed and considered for a grant of privileges by the Hospital through one of the following credentialing pathways:

- A. Standard Pathway: Through the processes described in Parts B and C of this Article XI of these Bylaws; or
- B. Limited Telemedicine Privilege Pathway: If the applicant is employed by a Distant Site Telemedicine Entity which entity has a current contract with the Hospital which meets the requirements of the CMS Conditions of Participation and the Joint Commission Standards, and the applicant holds privileges for the same scope of privileges at the Distant Site Telemedicine Entity as those sought at the Hospital, then credentialing processes may follow the special telemedicine credentialing requirements established by the CMS Conditions of Participation and the Joint Commission Standards, the current version of which and associated details shall be described in the Medical Staff Governing Documents.
 1. Threshold Requirement for Limited Telemedicine Privilege Pathway: MEC shall have approved the specific clinical services to be provided via telemedicine modality.
 2. Automatic Termination of Privileges: In addition to all other grounds as stated in these Bylaws at Article XII, Section 6, for privileges granted under this Section 4 shall automatically terminate at such time as:
 - (1) The Practitioner no longer maintains the same privileges at the Distant Site Telemedicine Entity as were granted by the Hospital ; or
 - (2) The contract between the Distant Site Telemedicine Entity and the Hospital terminates; or
 - (3) The Practitioner is no longer employed by the Distant Site Telemedicine Entity.

PART E: REAPPOINTMENT AND/OR RENEWAL OF CLINICAL PRIVILEGES

SECTION 1. APPLICATION

Each Practitioner or APP who wishes to be reappointed to the Medical Staff or renew his/her clinical privileges shall be responsible for returning a completed application, accompanied by all required supporting documents, by the specified deadline. In applying for reappointment or renewal of clinical privileges, the Practitioner or APP shall have the burden of producing adequate information to assure that he/she continues to meet those criteria outlined in the Medical Staff Bylaws. If granted by the Board, reappointment and/or renewal of clinical privileges shall be for a period not to exceed three (3) years.

SECTION 2. FACTORS TO BE CONSIDERED

Each recommendation concerning reappointment or renewal of clinical privileges or concerning change in staff category, where applicable, shall be based, in part, on the Practitioner's or APP's:

- A. Ethical behavior, current clinical competence, clinical judgment, and quality of care in the treatment of patients;
- B. Compliance with the Hospital policies and procedures and with the Medical Staff Governing Documents;
- C. Behavior in the Hospital, cooperation with Medical Staff and Hospital personnel as it relates to patient care or the orderly operation of this Hospital, and general attitude toward patients, the Hospital and its personnel;
- D. Ability to perform the clinical privileges requested;
- E. Satisfactory completion (as determined by the Chief of Service) of continuing education requirements related to the Provider's clinical privileges;
- F. Any other findings relevant to the Practitioner's or APP's competence and ability to perform professional duties and responsibilities and work harmoniously with others in the Hospital to ensure delivery of quality patient care, including but not limited to FPPE and OPPE, as applicable ; and
- G. Continues to meet Minimum Required Qualifications for Membership on the Active or Courtesy Medical Staff, if a Practitioner.

SECTION 3. REAPPOINTMENT/RENEWAL PROCEDURE

The completed application and supporting documents shall be forwarded to the appropriate Chief(s) of Service for evaluation of the Practitioner's or APP's demonstrated competence, professional performance, judgment, and clinical/technical skills, as indicated by quality monitoring and evaluation activities and other reasonable indicators of continuing qualifications, and by observation of the individual's ability to perform the clinical privileges granted. Peer recommendations will also be solicited and considered in recommending Medical Staff reappointment and/or continuation or specific privileges. Upon completion of the Chief of Service evaluation(s), the procedure provided in Part C (Processing Applications) shall be followed.

ARTICLE XII. CORRECTIVE ACTIONS

SECTION 1. SUMMARY SUSPENSION OF PRIVILEGES PRIOR TO INVESTIGATION

- A. The Chair of the MEC, the applicable Chief of Service, the CEO, and the Chair of the Board shall each have the authority to summarily suspend or restrict all or any portion of a Practitioner's clinical privileges ("Summary Suspension") upon the belief that failure to take such action may result in imminent danger to the health and/or safety of any individual. Prior to implementing such Summary Suspension, the person taking such action, shall, whenever practicable, consult with the other authorized individuals in this subsection.

- B. The Medical Director of the Trauma Services shall have the authority to summarily suspend or restrict all or any portion of the clinical privileges (“Summary Suspension”) of a Medical Staff Practitioner with patients under the care of the Trauma Service, upon the belief that failure to take such action may result in imminent danger to the health or safety of any trauma patient. Prior to implementing such Summary Suspension, the Medical Director of the Trauma Services shall, whenever practicable, consult with the Chair of MEC and the Chief of the affected Practitioner’s Service.
- C. Any individual who exercises authority under subsection (A) and (B) herein above shall immediately advise the CEO, the Chair of the MEC, Chief of Service and the suspended Practitioner of the Summary Suspension with a brief summary of the reason for its imposition. Such Summary Suspension shall be deemed an interim precautionary step in the professional review activity and shall not imply a final decision or finding of responsibility for the situation that prompted the Summary Suspension. Such Summary Suspension shall become effective immediately upon imposition and remain in effect unless or until lifted or modified by the CEO or the Board.
- D. Immediately upon the imposition of a Summary Suspension, the Chair of the MEC shall after consultation with the Chief of Service, transfer the care of the suspended Practitioner’s patients to another Practitioner. In making such a transfer, the wishes of the patient shall be considered whenever possible.
- E. When Summary Suspension is imposed pursuant to this section, the CEO or designee shall promptly provide the affected Practitioner with Notice regarding the right to request a review of the Summary Suspension. This Notice shall contain statements regarding each of the following:
1. the general reason(s) for the Summary Suspension;
 2. the Practitioner has three (3) business days from receipt of the Notice within which to request a review of the Summary Suspension to consider whether or not the imposition of the Summary Suspension was reasonable, based on the information known at the time the Summary Suspension was imposed, that failure to take such action may result in imminent danger to the health or safety of any individual;
 3. such request shall be written and sent to the CEO;
 4. the Practitioner shall have the right to meet with the Review Panel to rebut the need for the Summary Suspension. ;Failure to request a review in the time and manner specified in the Notice will result in a waiver of the Practitioner’s right to a review of the Summary Suspension, and the Summary Suspension shall remain in effect until modified or lifted by the CEO or Board.
- F. The Practitioner shall have three (3) business days from the date of receipt of such Notice, as indicated by proof of delivery, to submit a written request for a review to the CEO.
- G. If the Practitioner does not submit a written request for a review within three (3) business days of receipt of the Notice, she/he shall be deemed to have waived her/his right to such review and the Summary Suspension shall remain in effect until modified or lifted by the CEO or the Board.
- H. Upon receipt of the Practitioner’s request for review which meets the requirements as herein set forth, the Chair of the MEC, in consultation with the CEO, shall appoint an *ad hoc* committee (“Review Panel”) of three (3) Practitioners who are not partners, or relatives of the subject of the

investigation, or who have no prior involvement with imposition of the Summary Suspension and who are not economic competitors of the affected Practitioner. The Practitioner shall be given Notice as to the date, time, and place to meet with the Review Panel should the Practitioner wish to rebut the need for Summary Suspension. The Notice shall also list the patient records and/or other information supporting the imposition of the Summary Suspension. Prior to such meeting, the individual who imposed the Summary Suspension shall advise the Review Panel of the facts and circumstances known to him/her which led to imposition of the Summary Suspension and other considerations, if any, related thereto. Such advice may be oral or written, but shall be communicated to the Review Panel prior to the Review Panel's interview with the affected Practitioner.

- I. The only issue to be considered by the Review Panel is whether or not the imposition of the Summary Suspension was reasonable, based on the information known at the time the Summary Suspension was imposed, that failure to take such action may result in imminent danger to the health or safety of any individual.
- J. The Review Panel shall conclude its review as soon as possible and immediately thereafter report its results to the Chair of the MEC and CEO for their consideration. The report shall include a recommendation and reasons therefore, for one of the following actions: (1) continuation of the Summary Suspension as imposed; or (2) termination of the Summary Suspension; or (3) modification of the Summary Suspension. Every effort shall be made to complete such review within seven (7) days of the Summary Suspension. If the review is not completed within twelve (12) days of the Summary Suspension, the reasons for the delay shall be transmitted to the CEO so that he/she may consider, as soon as practicable, whether the Summary Suspension should be lifted pending completion of the investigation of the circumstances giving rise to the Summary Suspension according to the procedures described in Section 4 herein.
- K. It shall be the duty of the Chair of MEC and any Chief of Service to cooperate with the CEO in enforcing all Summary Suspensions. Summary Suspension shall continue until lifted or modified by the CEO or the Board.
- L. If the Summary Suspension is not terminated for any reason within seven 7 days of its imposition, the Chair of the MEC shall appoint an Investigating Committee Section 4 herein to investigate the circumstances that led to the Summary Suspension and report its evidence and findings to the Chair of MEC according to the procedures described in Section 4 herein, except that the Investigating Committee shall endeavor to complete its work with dispatch without sacrificing thoroughness, and within four (4) weeks of its appointment.

SECTION 2. GROUNDS FOR INITIATING AN INVESTIGATION

Whenever, on the basis of information and belief, the Chair of the MEC, the Chief of a Service, the Chair of the Board or the CEO has cause to question:

- A. The clinical competence of any Practitioner;
- B. The care or treatment of a patient or patients or management of a case by any Practitioner;
- C. The conduct of any Practitioner with regards to applicable ethical standards or a violation of the bylaws, policies, procedures, rules or regulations of the Hospital, Board or Medical Staff, including,

but not limited to the Hospital's quality improvement, risk management, and resource management programs; or

- D. The conduct of any Practitioner that may be considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others; then

a written request for an investigation of the matter shall be addressed to the Chair of MEC (unless the Chair of the MEC is the one that has cause to question a Practitioner's clinical competence, care or treatment, or conduct), which written request shall include a description of the incident(s), activity(ies), or conduct that form the basis for the request. The Chair of the MEC shall promptly notify the CEO, of such requests or of the Chair of the MEC's cause to question a Practitioner's clinical competence, care or treatment, or conduct and shall proceed as specified in Section 4 herein below. Nothing in this Article is meant to restrict the ability of any Professional Review Body, or Hospital quality activity, or peer review committee from conducting a review or informal investigation of a Practitioner's or APP's practice in furtherance of quality improvement, patient safety, FPPE or OPPE.

SECTION 3. SUSPENSION OF PRIVILEGES DURING INVESTIGATION

- A. At any time during an investigation, the Chair of the MEC, the applicable Chief of Service, the CEO, or the Chair of the Board may summarily suspend all or any part of the clinical privileges of the Practitioner being investigated whenever failure to take such actions may result in an imminent danger to the health or safety of any individual. Thereafter, procedures described in this Article, XII Section 1 C-L, shall apply, as applicable. Such suspension shall be deemed to be precautionary in nature and does not imply a finding as to any matter under investigation.
- B. It shall be the duty of the Chair of the MEC and any Chief of Service to cooperate with the CEO in enforcing all suspensions.

SECTION 4. INVESTIGATIVE PROCEDURE

If, after receiving the request for investigation and determines merit, or as otherwise provided for in the Bylaws, the Chair of the MEC determines:

- A. The request for investigation contains sufficient information to support a recommendation for corrective action, the Chair of the MEC shall make a recommendation for action to the MEC, with or without a personal interview with the Practitioner; or
- B. The request for investigation does not contain sufficient information to support a recommendation, the Chair of the MEC shall immediately appoint a subcommittee of the MEC to do so, or, appoint an *ad hoc* investigating committee ("Investigating Committee") to obtain the necessary information.
 - 1. The Investigating Committee shall consist of up to three (3) physicians, dentists, or podiatrists any of whom may or may not hold an appointment to the Medical Staff. This committee shall not include partners, or relatives of the subject of the investigation, nor any individual in direct economic competition with the subject of the investigation.
 - 2. The Investigating Committee, whether it be a subcommittee of the MEC or an *ad hoc* committee, shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as required.

3. The Investigating Committee may require a physical and/or mental examination of the Practitioner by a physician(s) satisfactory to the Investigating Committee and that the results of such examination be made available for the Investigating Committee's consideration.
4. The subject of the investigation shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the Practitioner shall be informed of the general nature of the evidence supporting the investigation and shall be invited to discuss, explain or refute it. The proceedings of an Investigating Committee are considered an administrative matter and not an adversarial proceeding. Practitioner's meeting with the Investigating Committee is not a hearing, and none of the procedural rules provided in Article XIII with respect to hearings, including the right to have legal counsel present, apply. A summary of the meeting with the Practitioner shall be made by the Investigating Committee and included with its report to the Chair of the MEC.
5. The Investigating Committee shall make a report of the evidence and its findings to the Chair of the MEC within six (6) weeks of its appointment (within four (4) weeks of its appointment for Practitioners who are currently Summarily Suspended (See Section 1 above), unless otherwise directed by the MEC Chair. The Investigating Committee may obtain from the Chair of the MEC and upon demonstration of good cause an extension within which to complete its investigation.

SECTION 5. RECOMMENDATIONS FOR CORRECTIVE ACTIONS

- A. After the Chair of the MEC receives the Investigating Committee's report, the report will be reviewed at the next scheduled MEC meeting so long as the report is received at least seven (7) days prior to the scheduled MEC meeting. However, the MEC Chair can adjust the timeframe for review as reasonably necessary or can schedule a special MEC meeting to review the report. The MEC may recommend for Board action any appropriate action in furtherance of safe, quality care and performance improvement, including but not limited to:
 1. No corrective action;
 2. A written warning;
 3. A letter of reprimand;
 4. Requirement for additional medical education;
 5. Referral to and successful participation in an appropriate resource including physical, psychiatric or emotional diagnostic and/or rehabilitative or consultative programs;
 6. Supervision;
 7. Concurring consultation prior to patient treatment;
 8. Suspension of clinical privileges for a period of time;
 9. Reduction or revocation of clinical privileges; or
 10. Termination of staff appointment.

- B. If the recommendation of the MEC would entitle the affected Practitioner to a hearing in accordance with Article XIII, the recommendation shall be forwarded to the CEO, who shall promptly communicate the fact of such right to the affected Practitioner by Notice. The CEO shall then hold the recommendation until after the Practitioner has exercised or waived the right to a hearing and appeal as provided in Article XIII. At that time, the CEO shall forward the recommendation of the MEC to the Board, together with all supporting documentation, and any decision(s) of the Hearing Panel and Appellate Review, as applicable. The Chair of the MEC or a designee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.
- C. If the recommendation of the MEC includes a recommendation for the imposition of an immediate suspension or restriction of clinical privileges based on the belief that failure to take such action may result in imminent danger to the health and/or safety of any individual, the recommendation will take effect immediately and remain in effect until modified by the CEO or Board. The CEO shall promptly give Notice to the affected Practitioner of the recommended suspension/restriction, its immediate effect, and her/his right as provided in Section I herein.
- D. If the recommendation of the MEC would not entitle the individual to a hearing, in accordance with Article XIII, Section 2, the recommendation shall be made to the Board through the Chair of MEC for final action by the Board.
- E. In the event the Board considers modification of an action of recommendation of the MEC and such modification would entitle the individual to a hearing, the affected Practitioner shall be notified by the CEO, and no final action thereon shall be taken by the Board until the individual has exercised or waived the right to a hearing and appeal.
- F. In circumstances where the affected Practitioner is serving a Summary Suspension imposed prior to or during an investigation, the MEC recommendation shall, in addition to other recommendations, make a recommendation to the CEO and the Board as to whether or not the Summary Suspension should be lifted, modified or continued.

SECTION 6. AUTOMATIC SUSPENSION OF PRIVILEGES OR TERMINATION OF MEMBERSHIP

Suspension of all clinical privileges, or termination of membership as well as all clinical privileges, shall occur automatically as indicated upon the occurrence of any of the following events:

- A. For any Practitioner who practices at the Hospital pursuant to an exclusive agreement between the Hospital and the group/entity that employs the Practitioner: the termination of the agreement, or the termination of the Practitioner's employment/association with such group or other entity, shall result in automatic termination of the Practitioner's Medical Staff membership (except in the event the Practitioner also practices at the Hospital pursuant to another arrangement or agreement with the Hospital and/or through The University of Florida College of Medicine-Jacksonville).
- B. Revocation of license to practice shall result in automatic termination of membership. Suspension of license to practice shall result in automatic suspension of all clinical privileges for a concomitant period of time and prompt initiation of an investigation in accordance with this Corrective Actions Article.

- C. Failure to take appropriate steps to cause license renewal, thereby rendering the license inactive, shall result in automatic suspension of all clinical privileges. The suspension shall remain in effect until proof of current licensure has been submitted. If the Practitioner remains suspended under this Subsection at the time of reappointment is considered, the Practitioner will not be considered for reappointment and the membership automatically terminated.
- D. Failure to report to the Hospital any patient care related action or other action that could impact the Practitioner's Florida license taken by any state medical licensure agency within thirty (30) days of the action taken by the state licensure agency shall result in automatic termination of membership. Such "patient care related" action shall be broadly construed and shall include but not limited to commencement of an investigation, the imposition of probation, any requirement, or fine.
- E. Failure to provide the Hospital's Office of Medical Staff Services with current certificate to prescribe or administer any controlled substances, if required for the exercise of the Practitioner's clinical privileges, shall result in automatic suspension of membership until proof of current certification has been submitted. If the suspension remains pending at the time of reappointment, the applicant will not be considered for reappointment and the membership automatically terminated.
- F. Failure to appear at a Medical Staff or Hospital committee meeting to which the Practitioner has been invited, and at which a discussion of the Practitioner's clinical practice or professional conduct is an issue unless excused by the MEC Chair upon a showing of good cause, shall result in automatic suspension of membership. Such suspension will be automatically rescinded upon the Practitioner's participation in a rescheduled conference, so long as the Practitioner's participation at the meeting occurs within 45 days (or other date as may be required by the MEC Chair when excusing the Practitioner from attendance), otherwise the Practitioner's membership shall automatically terminate on the 46th day (or the day following such other date required by the MEC Chair when excusing the Practitioner from attendance).
- G. Failure, after warning, to prepare any medical record pursuant to Medical Staff Policies or Bylaws shall result in automatic suspension of all clinical privileges until such time as the proper medical record(s) has been prepared, or for such other period of time as may be determined by MEC. If the Practitioner remains suspended under this Subsection at the time reappointment is considered, the Practitioner will not be considered for reappointment and the membership automatically terminated.
- H. Failure to provide the Hospital's Office of Medical Staff Services with proof of professional liability insurance coverage as described in the Medical Staff Governing Documents and in the amounts established by the Board shall result in automatic suspension of membership. Such suspension shall be rescinded upon the submission of proof of acceptable professional liability insurance. If the Practitioner remains suspended under this Subsection at time of reappointment is considered, the Practitioner will not be considered for reappointment and the membership automatically terminated.
- I. Failure of the Practitioner to maintain an office or residence in sufficient proximity to the Hospital to be able to provide continuity or quality of care to the Practitioner's patients as defined by Medical Staff policies shall result in automatic suspension of membership, unless the appointee has requested waiver of such requirement from the Board and is awaiting final action on such request.

- J. Exclusion from participation in Medicare or Medicaid shall result in automatic suspension of membership. The suspension shall remain in effect until proof of participation has been submitted to the Medical Staff Services Office. If proof of participation has not been received by the Medical Staff Services Office within thirty (30) days, on the thirty-first (31st) day, the Practitioner shall be automatically terminated.
- K. Automatic termination of membership shall occur upon expiration of a present term of appointment, when failure to submit a complete application by the stated deadline results in insufficient time to process the application before the current appointment expires.
- L. Failure to provide a written request to return from a leave of absence prior to the expiration of the leave of absence shall resolve in automatic termination of the Practitioner's Medical Staff Membership.
- M. Failure, after warning, to cooperate with the Hospital's Focused Professional Practice Evaluation (FPPE) or Ongoing Professional Practice Evaluation (OPPE) programs and processes shall result in automatic termination of privileges pertaining to the FPPE or OPPE. If this constitutes all privileges held, Medical Staff membership will also be terminated.
- N. Failure to provide the Office of Medical Staff Services a current e-mail, phone number and office address within thirty (30) days of change.

Upon the occurrence of any of the events described in Subsections A-N herein, the CEO, or designee shall give the affected Practitioner Notice of the automatic termination or suspension and the grounds for the termination/suspension. Notice shall be sent to the address on record at the Hospital's Office of Medical Staff Services.

Within fourteen (14) days of such Notice, the affected Practitioner may present written evidence to the CEO that negates the grounds for the automatic suspension or termination. If the CEO determines, in the CEO's sole discretion, that the written evidence is sufficient to negate the grounds for the automatic suspension or termination, the CEO shall give Notice of that determination to the affected Practitioner and copy the Chair of MED and Chief of Service, and the automatic suspension or termination shall be considered void from the beginning.

It is the responsibility of the Chair of the MEC, and the appropriate Chief of Service, with the cooperation of the CEO, to enforce all automatic suspensions and terminations.

SECTION 7. CONFIDENTIALITY

All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are deemed confidential and privileged to the fullest extent permitted under the provisions of federal and/or state law. Committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed "Professional Review Bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE XIII. FAIR HEARING AND APPEALS PROCEDURES

PART A: INITIATION AND SCHEDULING OF A HEARING

SECTION 1. RIGHT TO HEARING

Except as provided in Section 2 of this Article, a Practitioner or applicant is only entitled to a hearing whenever any of the following adverse recommendations or adverse actions without a recommendation has been made or taken by the MEC, or by the Board, in the event the Board intends to take such adverse action without a similar recommendation from the MEC:

- A. Denial of initial Medical Staff appointment;
- B. Denial of requested advancement in Medical Staff category;
- C. Denial of Medical Staff reappointment;
- D. Revocation of Medical Staff appointment;
- E. Denial of requested initial clinical privileges;
- F. Denial of requested increased clinical privileges;
- G. Decrease of clinical privileges;
- H. Suspension of clinical privileges; and
- I. Requirement of mandatory concurring consultation prior to patient treatment.

No Practitioner or applicant shall be entitled to more than one hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right. A hearing right provided as to an initial or proposed adverse recommendation or action, whether or not exercised by the affected Practitioner or applicant, shall satisfy the requirement for a hearing right as to the final recommendation or action, which is based on the same subject matter.

SECTION 2. ACTIONS NOT GIVING RISE TO HEARING RIGHT

Recommendations for, or imposition of, any of the following actions by the MEC or the Board does not constitute grounds for a hearing:

- A. Denial of Medical Staff application, appointment, reappointment or requested advancement in membership category, or revocation of Medical Staff appointment based on current inability or failure to meet any one of the threshold, minimum objective criteria for appointment set forth in Article I, Section 2 herein or the qualifications for membership category set forth in Article II herein;
- B. Automatic suspension of privileges or termination of membership pursuant to Article XII, Section 6 herein;

- C. Summary suspension pursuant to Article XII, Section 1 or 3 for a period 14 days or less pending an investigation;
- D. Denial or termination of temporary or disaster privileges under Article XI, Part D, Section 2 and 3;
- E. Requirement for supervision or observation of a Practitioner or applicant that does not restrict the clinical privileges of the Practitioner or applicant;
- F. Requirement for general or corrective counseling;
- G. Issuance of a letter of warning, admonition or reprimand;
- H. Denial of a request for waiver from the Board of any criteria set forth of the Medical Staff Bylaws;
- I. Denial of a request for clinical privileges on the basis that approval would contravene the terms of an exclusive agreement between the Hospital and any other party;
- J. Denial or revocation of Medical Staff appointment when the denial of privileges pursuant to subsection (I) herein constitutes all privileges requested or previously held;
- K. Denial of reappointment or request for advancement in membership category based on the inability to meet the qualifications for either the Active or Courtesy category;
- L. Denial of a request to be granted privileges to perform a procedure or service not currently provided at the Hospital; or
- M. Denial of a request to be granted privileges for failure to meet the Medical Staff criteria for privileges sought.

SECTION 3. NOTICE OF ADVERSE RECOMMENDATION OR ACTION AND REQUEST FOR HEARING

- A. When a recommendation is made or action is taken that entitles a Practitioner or applicant to a hearing, the affected Practitioner or applicant shall promptly be given written Notice by the CEO or his/her designee. This Notice shall contain:
 - 1. A statement of the recommendation/action made/taken and the general reasons for it;
 - 2. A statement that the Practitioner or applicant has thirty (30) days from receipt of Notice within which to send to the CEO a written request for a hearing on the recommendation;
 - 3. A statement that failure to request a hearing in the time and manner specified will result in a waiver of the Practitioner or applicant's right to a hearing and acceptance of the adverse recommendation;
 - 4. A summary of the Practitioner or applicant's rights during the hearing as provided for in Part B of this Article; and
 - 5. If the hearing is regarding a Summary Suspension, a statement that the hearing is limited to determining whether or not the imposition of the summary suspension was reasonable

based on information known at the time the summary suspension was imposed that the failure to take such action may result in imminent danger to the health or safety of any individual.

- B. The affected Practitioner or applicant shall have thirty (30) days from the date of receipt of such Notice to submit a written request for a hearing to the CEO.
- C. If the affected Practitioner or applicant does not submit a written request for a hearing within thirty (30) days of receipt of the Notice, the Practitioner or applicant shall be deemed to have waived the right to such hearing and to have accepted the recommendation and/or action, and any action taken by the Board shall be final.

SECTION 4. SCHEDULING AND NOTICE OF HEARING

Within fifteen (15) days of receipt of the affected Practitioner or applicant's written request for a hearing, the CEO or designee shall schedule the hearing and give Notice of its time, place and date, to the Practitioner or applicant. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days from the date of Notice of the hearing, unless an earlier hearing date has been mutually agreed to in writing.

- A. The Notice shall also:
 - 1. Include a concise statement of the specific reasons for the recommendation giving rise to the hearing;
 - 2. List the patient records and other information supporting the recommendation;
 - 3. In accordance with Section 5 of this Part, list the witnesses who are expected to testify or present evidence at the hearing in support of the recommendation, and inform the Practitioner or applicant of the obligation to provide the CEO within fifteen (15) days of receipt of the Notice with a list of witnesses the Practitioner or applicant expects to testify or present evidence on behalf of the Practitioner or applicant; and
 - 4. Inform the Practitioner or applicant of the right to be represented at the hearing by an attorney or other person and the Practitioner or applicant's obligation to advise the CEO within fifteen (15) days of the Notice of the name and address of such attorney or other person.
- B. The statement of reasons and list of supporting documents may be amended or supplemented at any time, even during the hearing, provided that the new material is relevant to the appointment or clinical privileges of the affected Practitioner or applicant, and that the Practitioner or applicant and counsel have adequate notice of the amended or supplemented materials.

SECTION 5. EXCHANGE OF WITNESS LISTS

A written list of the names and contact information of the persons expected to give testimony or present evidence in support of the recommendation giving rise to the hearing shall be provided to the affected Practitioner or applicant with the Notice of hearing. Within fifteen (15) days of the Notice of the hearing, the affected Practitioner or applicant shall provide a written list of names, addresses and phone numbers of the persons expected to give testimony or present evidence at the hearing on the Practitioner or applicant's

behalf. The witness list of either party may be supplemented or amended at any time prior to the hearing, so long as there is adequate notice to the other party.

PART B: HEARING PROCEDURE

The purpose of the hearing shall be to recommend a course of action to the Board, and the duties of the Hearing Panel shall be so defined and so carried out. The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in this Article.

SECTION 1. APPOINTMENT OF HEARING PANEL

When a hearing is requested, the CEO, after considering the recommendations of the Chair of the MEC (and that of the Chair of the Board, if the hearing is occasioned by a Board determination), shall appoint a Hearing Panel. A Hearing Panel shall be composed of not less than three (3) individuals who are either dentists, physicians or podiatrists, and who are all peers of the affected Practitioner or applicant. Appointees to the Hearing Panel shall not have actively participated in the consideration of the matter involved at any previous level. The Hearing Panel shall not include any person who is in direct economic competition with, or related to, the affected Practitioner or applicant. Knowledge of the matter involved, however, shall not preclude any person from serving as a member of the Hearing Panel. The CEO may designate a Chair of the Hearing Panel. .

SECTION 2. APPOINTMENT OF PRESIDING OFFICER

- A. The CEO shall select a person to act as the Presiding Officer during the hearing.
- B. The Presiding Officer may either be the Chair of the Hearing Panel, or a person who is not a member of the hearing panel, including an attorney, so long as such person has not actively participated in consideration of the matter at any previous level, is not in direct economic competition with, or related to, the affected Practitioner or applicant. Knowledge of the matter involved, however, shall not preclude any person from service as the Presiding Officer.
- C. The Presiding Officer shall:
 - 1. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral testimony and/or documentary evidence and that decorum is maintained throughout the hearing;
 - 2. Determine the order of proceeding throughout the hearing;
 - 3. Have the authority and discretion to make rulings, consistent with these Bylaws, on all questions of procedure and admissibility of evidence; and
 - 4. Have the authority to remove any person who is disruptive to the orderly and professional process of the hearing.
- D. The Presiding Officer may be advised on these matters by legal counsel to the Hospital.
- E. The Presiding Officer must not act as a prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel

and be a legal advisor to it but shall not be entitled to vote on its recommendations, unless the Presiding Officer is the Chair of the Hearing Panel.

SECTION 3. RIGHTS OF AFFECTED PRACTITIONER OR APPLICANT

During the hearing, the affected Practitioner or applicant has the right to:

- A. Be represented by an attorney or any other person;
- B. Call, examine and cross-examine witnesses;
- C. Present evidence determined to be relevant by the Presiding Officer; and
- D. Submit a written statement at the close of the hearing, in accordance with Section 10(E) of this Part.

SECTION 4. RIGHTS OF THE HOSPITAL

During the hearing, the Professional Review Body whose recommendation prompted the hearing has the right to:

- A. Be represented at the hearing by an attorney or any other person;
- B. Call, examine, and cross-examine witnesses, including the affected Practitioner or applicant;
- C. Present evidence determined to be relevant by the Presiding Officer; and
- D. Submit a written statement at the close of the hearing, in accordance with Section 10(E) of this Part.

SECTION 5. REQUESTS FOR DOCUMENTS

Prior to the hearing, each party shall provide to the other party documents in its possession that it plans to rely on as evidence at the hearing.

Providing documents to the other party shall not waive any privilege or confidentiality provided by law or policy to those documents; all documents will remain subject to such privilege and confidentiality protections.

SECTION 6. POSTPONEMENT OF HEARING

Postponement of the hearing beyond the time originally noticed may be requested by either party but permitted only by the Presiding Officer upon a showing of good cause.

SECTION 7. FAILURE TO APPEAR

The affected Practitioner or applicant shall appear and participate at the hearing. Failure of the affected Practitioner or applicant to appear and participate in the hearing, without good cause as determined by the Presiding Officer, shall be deemed to constitute acceptance of the recommendation(s) or action(s) that

prompted the hearing and a waiver of the right to a hearing. Such recommendation(s) or pending action(s) shall become final and effective upon Board action.

SECTION 8. ATTENDANCE BY PANEL MEMBERS

Recognizing that it may not be possible for all members of the Hearing Panel to be continually present during the hearing and the importance of concluding a hearing within a reasonable timeframe, the hearing shall continue even though all members of the Hearing Panel are not present at all times. The fact that not all panel members were physically present at all times during the hearing shall not invalidate it.

SECTION 9. HEARING RECORD

- A. The Hospital shall maintain a record of the hearing by securing the presence of a court reporter or by an electronic recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcripts or electronic recording shall be made available to the affected individual at their expense.
- B. The Presiding Officer may, but shall not be required to, order that oral evidence is taken only on oath or affirmation administered by a person entitled to notarize documents in this State.

SECTION 10. PRESENTING OF EVIDENCE

- A. The Professional Review Body whose recommendation prompted the hearing shall present its evidence first. Upon completion of its presentation, the affected Practitioner or applicant shall present evidence. The Professional Review Body shall then have an opportunity to rebut any evidence presented by the affected Practitioner or applicant.
- B. Both parties to the hearing shall be permitted to present evidence determined to be relevant by the Presiding Officer, regardless of the admissibility of such evidence in a court of law. The Presiding Officer shall admit any evidence that is commonly relied upon by reasonably prudent persons in the conduct of serious affairs.
- C. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence.
- D. The Hearing Panel shall have the discretion to take official notice of any relevant matters as to which the Panel believes there can be no reasonable dispute. Official notice may also be taken of generally recognized technical or scientific facts within the specialized knowledge of any member of the Hearing Panel. Participants in the hearing shall be informed of the matters to be officially noticed, and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the officially noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
- E. At the close of the hearing, each party shall have the right to submit a written statement concerning any issue, procedure, or alleged fact. Such written statement may take the form of a memorandum of points and authorities. The Hearing Panel may request that either party file such a statement or memorandum.

SECTION 11. STANDARD OF PROOF

The affected Practitioner or applicant has the burden of proving that the recommendation that prompted the hearing was unreasonable or not supported by evidence. Unless the Practitioner or applicant so proves, the Hearing Panel shall recommend in favor of the Professional Review Body making the recommendation.

SECTION 12. ADJOURNMENT AND CONCLUSION

The Presiding Officer may, without special notice, adjourn and reconvene the hearing at the convenience of the participants. Upon the conclusion of the presentation of oral and written evidence, the hearing shall be closed.

SECTION 13. DELIBERATIONS AND RECOMMENDATION OF THE HEARING PANEL

- A. Within twenty (20) days after conclusion of the hearing, the Hearing Panel shall:
1. Conduct its deliberations outside the presence of any other person, except the Presiding Officer, and upon the request of the Hearing Panel, appropriate Hospital support personnel (including the Hospital's attorney);
 2. Render a written report containing its recommendation and a concise summary of its reasons therefore, in accordance with subsection (B) herein. In the preparation of its written report with recommendation, the Hearing Panel may obtain assistance from the Presiding Officer or Hospital support staff (including the Hospital's attorney); and
 3. Deliver its report to the CEO.
- B. The recommendation shall be based on material allowed into evidence at the hearing, which may include: oral testimony of witnesses; documentary evidence; all officially noticed matters; and any written statement or memorandum of points and authorities submitted by the parties in accordance with Section 10(E) of this Part. The recommendation shall comport with the burden of proof requirement set forth in Section 11 of this Part. Agreement by a majority of all the members of the Hearing Panel shall be required for the issuance of its report.
- C. Upon its receipt, the CEO shall promptly communicate the Hearing Panel's report by Notice to the Professional Review Body whose adverse recommendation prompted the hearing, to the MEC and to the affected Practitioner or applicant. The CEO shall also promptly forward the Hearing Panel's report to the Board who shall take further action once the affected Practitioner or applicant exhausts or waives any appeal rights. The CEO shall make available all supporting documentation and transcripts of the hearing to the Board for its review.

PART C: APPELLATE REVIEW

SECTION 1. REQUEST FOR APPELLATE REVIEW

Within ten (10) days of notification by the CEO or designee of an adverse recommendation from the Hearing Panel, the affected Practitioner or applicant may request appellate review. The request, which shall be in writing, and be delivered to the CEO, shall include a brief statement of the facts supporting the grounds for appeal. The CEO shall promptly forward the request to the Chair of the Board. If such appellate review is not requested in a timely fashion and in the manner required, the affected Practitioner or applicant shall

be deemed to have waived the right to an appeal and to have accepted the adverse recommendation of the Hearing Panel.

SECTION 2. GROUNDS FOR APPEAL

The grounds for an appeal are that:

- A. There was substantial failure on the part of the Hearing Panel to comply with the hearing process set forth in Part B herein, and such failure significantly prejudiced the affected Practitioner or applicant; or
- B. The recommendations of the Hearing Panel were arbitrary or capricious; or
- C. The recommendations of the Hearing Panel were not supported by evidence in the record of the hearing.

SECTION 3. SCHEDULING AND NOTICE OF APPELLATE REVIEW

Within ten (10) days of receipt of a request for an appeal, the CEO shall schedule and arrange for an appellate review. The date of appellate review shall be not less than twenty (20) days nor more than forty-five (45) days from the date of receipt of the request; provided, however, that when a request for appellate review is from a Practitioner or applicant who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request. The CEO or designee shall communicate the time, date, and place where the appellate review shall occur by Notice to the affected Practitioner or applicant.

SECTION 4. APPOINTMENT OF APPELLATE REVIEW PANEL

- A. The Chair of the Board shall appoint an Appellate Review Panel (“Appeal Panel”) to consider the record upon which the Hearing Panel recommendation was made. The Appeal Panel shall be composed of not less than three (3) and no more than five (5) persons, who may be members of the Board or others, including but not limited to reputable persons outside the Hospital and at least two (2) of whom hold Active Medical Staff membership.
- B. Appointees to the Appeal Panel shall not have actively participated in the consideration of the matter involved at any previous level. Nor shall it include any individual who is in direct economic competition with or related to the affected Practitioner or applicant. Knowledge of the matter involved, however, shall not preclude any person from serving as a member of the Appeal Panel. The Chair of the Board shall designate a Chair of the Appeal Panel. The Chair of the Board for good cause may extend the time for appellate review. The Chair of the Appeal Panel may, without special notice, adjourn and reconvene the review meeting at the convenience of the participants.

SECTION 5. ATTENDANCE BY APPELLATE REVIEW PANEL MEMBERS

A majority of the members of the Appeal Panel must be present at each meeting of the Appeal Panel.

SECTION 6. PURPOSE AND STANDARD OF APPELLATE REVIEW

- A. The purpose of the appellate review is to ascertain the fairness of the hearing procedure and to determine whether the evidence and other testimony and documents support the recommendation

of the Hearing Panel submitted at the hearing. The Appeal Panel shall review the hearing record, including all documentary evidence and any written statements submitted by the parties before making its determinations and recommendations to the Board.

- B. The Appeal Panel shall uphold the recommendation of the Hearing Panel unless it finds that:
 - 1. The Hearing Panel's recommendation was not supported by evidence in the record, or was arbitrary or capricious; or
 - 2. The procedures followed in reaching the recommendation were not fair or not in substantial compliance with the hearing process set forth in Part B herein, and such unfairness or lack of compliance significantly prejudiced the affected Practitioner or applicant.

SECTION 7. ADDITIONAL EVIDENCE

- A. The Appeal Panel may not accept additional oral or written evidence, unless so directed by the Board upon a good faith belief that the affected Practitioner or applicant was arbitrarily or capriciously denied the opportunity to present such evidence at the hearing.
- B. Nevertheless, the Appeal Panel may, in its sole discretion, invite the affected Practitioner or applicant to appear and make a statement.

SECTION 8. RECOMMENDATION OF THE APPELLATE REVIEW PANEL

- A. Within fourteen (14) days of the date noticed for the appellate review, the Appeal Panel shall render a written report containing a recommendation in accordance with this Section and a concise summary of the reasons justifying its recommendation, and forward such report to the Board and the CEO. The recommendation shall comport with the standard of review set forth in Section 6 of this Part. If the Appeal Panel's recommendation does not uphold the Hearing Panel's recommendation, it may recommend referral back to the Hearing Panel or the MEC, as appropriate, with instructions for remedial action. Agreement by a majority of all the members of the Appeal Panel shall be required for the issuance by the Appeal Panel of any recommendation or report. In the preparation of its written report with recommendation, the Appeal Panel may obtain assistance from the Hospital support staff (including the Hospital attorney).
- B. Upon its receipt, the CEO shall forward the Appeal Panel's report with recommendation to the Hearing Panel, the Professional Review Body whose adverse recommendation prompted the hearing, the MEC, the Board and communicate the report with recommendation by Notice to the affected Practitioner or applicant.

PART D: FINAL DECISION OF THE BOARD

SECTION 1. FINAL BOARD ACTION

- A. The Board may affirm, modify, or reverse the recommendation presented to it for final action, after exhaustion or waiver of hearing and appeal rights by the affected Practitioner or applicant or, in its sole discretion, refer the matter for further review and recommendations, to be completed within 30 days or less, as per the Board's direction.

- B. If the Board proposes an adverse final action inconsistent with that of the final recommendation before it, the Chair of the Board shall consult with the MEC Chair before taking such final action.
- C. Final Board Action shall be promptly communicated in writing to the CEO (once any actions as may be required under Section 1(A) and (B) of this Part are concluded). Thereafter, the CEO shall give Notice of the Final Board Action to the affected Practitioner or applicant, the panel(s) providing the recommendation presented to the Board and the Chair of MEC who shall distribute to other Professional Review Bodies as appropriate.

SECTION 2. FURTHER REVIEW

Final Board Action is effective immediately and is not subject to further review. No Practitioner or applicant shall be entitled as a matter of right to more than one hearing or appellate review on any matter.

PART E: APPLICATION FOR STAFF APPOINTMENT AFTER ADVERSE FINAL ACTION

In the event that the Board denies initial appointment or reappointment to the Practitioner or applicant, or revokes or terminates the Practitioner's Medical Staff appointment and/or clinical privileges, that Practitioner or applicant may not again apply for Medical Staff appointment or clinical privileges at this Hospital for a period of five (5) years, unless the Board provides otherwise in its written final decision.

ARTICLE XIV. CONFLICT MANAGEMENT

- A. In the event of a conflict between members of the Active Staff and the MEC regarding the adoption of any rule, regulation or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by twenty-five percent (25%) of the members of the Active Staff, the matter shall be reviewed by the Conflict Resolution Committee ("CRC").
- B. A CRC shall be formed consisting of up to five (5) representatives of the Active Staff designated by the Active Staff members submitting the petition and an equal number of representatives of the MEC appointed by the Chair of the MEC. The Hospital CEO or designee shall be an ex-officio non-voting member of any CRC.
- C. The members of the CRC shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting patient safety and healthcare quality.
- D. Any CRC recommendation which is approved by a majority of its Active Staff representatives and a majority of its MEC representatives shall be submitted to the Board for consideration and subject to final approval by the Board. If agreement cannot be reached by a majority of the Active Staff and a majority of the MEC representatives, the members of the CRC shall individually or collectively report to the Board regarding the unresolved differences for consideration by the Board in making its final decisions regarding the matter in dispute.
- E. In the event of a dispute between leaders or segments of the Medical Staff, the matter in dispute shall be resolved by a CRC composed of equal number of members representing opposing viewpoints who are appointed by the Chair of the MEC. The members of the CRC shall proceed in accordance with Sections C and D above.

- F. In the event of a dispute between the Board and the Organized Medical Staff or the MEC, the matter in dispute shall be handled according to the Hospital “Conflict Management” policy.
- G. If deemed appropriate by the Chair of the MEC and the CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issues.

**ARTICLE XV. PROMULGATION, AMENDMENT, REVISION, AND ADOPTION OF
MEDICAL STAFF GOVERNING DOCUMENTS**

SECTION 1. BYLAWS

- A. As herein delegated by the Board, Amendments may be proposed by the MEC, another standing Medical Staff committee, a Hospital representative or by 25% of the membership of the Active Medical Staff. Such proposals shall be forwarded to the Bylaws and Policy Committee (“BPC”) for consideration.
- B. Within 60 days after receipt of such proposal, the BPC shall review and analyze the proposal, prepare a written report with recommendations concerning the proposal and deliver report to the Chair of MEC.
- C. The MEC will review the proposal along with BPC’s report and recommendations and thereafter will make a recommendation which will be presented for a vote to the Active Medical Staff.
- D. Ordinarily, proposed amendments shall be presented at the next annual meeting of the Medical Staff, along with the recommendation of the MEC and the BPC.

Under more urgent circumstances as determined by the MEC, proposed amendments may be presented at other regular or special meeting of the Medical Staff or proposed electronically to the Active Medical Staff for consideration. Proposed amendments are then submitted to the Medical Staff for a mail ballot, which can be electronic or paper, to be returned to the Chair of MEC or designee within time specified. A majority of the votes cast in favor of the amendment by Active Staff members is required before the amendment may be presented to the Board for approval.

- E. The MEC may, without vote by the Medical Staff, recommend such amendments to the Bylaws as are, in the MEC’s judgment, technical or legal modifications or clarifications, reorganization or renumbering or due to punctuation, spelling or other errors of grammar or expression. Such amendments become effective immediately upon approval by the Board.
- F. Any amendment shall become effective only after approval by the Board.
- G. Neither the Board nor the Medical Staff may unilaterally change the Medical Staff Bylaws.

SECTION 2. OTHER MEDICAL STAFF GOVERNING DOCUMENTS

Medical Staff rules and regulations, policies, and manuals may be necessary to articulate the detailed procedures of the basic steps and key elements principles found within these Bylaws, and to regulate the proper conduct of Medical Staff organizational activities and the clinical practices of Practitioners in the Hospital. Such documents may be recommended by the MEC or proposed by majority vote of the Medical Staff, subject to the approval of the Board, in accordance with the following procedures.

- A. Rules and Regulations: As herein delegated by the Board, the MEC may propose any rule/regulation, or any amendment or revision to any existing rule/regulation, so long as the rule/regulations or any modification thereto is distributed to the members of the Medical Staff for review and comment, in accordance with such procedures as are approved by the MEC, before the proposed rule/regulation or modification is adopted by the MEC.
- B. Medical Staff Policies and Manuals: As herein delegated by the Board, the MEC may propose and adopt any policy or manual, or any amendment or revision to any existing policy/manual, as long as the policy/ manual or change adopted by MEC is thereafter shall be communicated to the Medical Staff.
- C. Adoption by Medical Staff Initiative: Rules, regulations, manuals and policies, and any modifications thereto, may also be proposed to the Board by the Medical Staff. Proposed rules, regulations or policies may be brought before the Active Medical Staff by petition signed by fifteen (15%) of the members of the Active Staff. Any such proposed rules, regulations or policies shall be submitted to the MEC for review and comment before such rule, regulation, or policy is voted on by the Active Staff. A majority vote is required for the proposal to be submitted to the Board. A 2/3 majority vote of the Active Medical Staff is required for the proposal to be submitted to the Board. Any rule, regulation or policy approved by the Active Staff shall be presented to the Board along with any comments from the MEC. All such proposed Medical Staff rules, regulations, manuals or policies shall become effective only after approval by the Board.

Approved by Board of Directors June 28, 2023

Kjh

8/7/23