

**NATIONWIDE CHILDREN'S HOSPITAL  
COLUMBUS, OHIO**

**MEDICAL STAFF  
BYLAWS MANUAL**

**Revised November 2014**

**MEDICAL STAFF OFFICE  
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**ARTICLE 1: BYLAWS MANUAL**

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## **ARTICLE I. BYLAWS**

### **1.1. Adoption**

The Bylaws shall be adopted at a regular or special meeting of the Medical Staff. These Bylaws shall replace any previous Bylaws and shall become effective when approved by the Board of Directors.

◆ ADOPTED BY THE MEDICAL STAFF OF NATIONWIDE CHILDREN'S HOSPITAL:  
**November 14, 2014**

◆ APPROVED BY THE BOARD OF DIRECTORS OF NATIONWIDE CHILDREN'S HOSPITAL:  
**November 28, 2014**

### **1.2. Preamble**

**Whereas**, Nationwide Children's Hospital is a non-profit corporation organized under the laws of the State of Ohio; and

**Whereas**, its purpose is to serve primarily as a Hospital providing patient care, education and research to children and adults with childhood illnesses; and

**Whereas**, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Board of Directors, and that the cooperative efforts of the Medical Staff, the Chief Medical Officer, the Chief Executive Officer, and Board of Directors are necessary to fulfill the Hospital's obligations to its patients;

**Therefore**, the practitioners in this Hospital shall organize themselves into a Medical Staff in conformity with the Medical Staff Manuals.

### 1.3. Delegation of Authority

Since final accountability for the quality of care rendered at Nationwide Children's Hospital rests with the Board of Directors, they, as the governing body, grant to qualified and authorized persons the privilege of practicing their profession as members of the Medical Staff of Nationwide Children's Hospital. The Board of Directors appoints said persons to the Medical Staff upon the recommendation of the duly authorized Officers of the Medical Staff, its committees, and its members.

The Medical Staff is responsible to the Board of Directors to see that Hospital credentialed persons treat only those diseases or injuries they are qualified to treat as defined by their professional credentials, as delineated at the time of appointment and of reappointment thereafter, and as permitted by the Medical Executive Committee.

The Board of Directors has delegated authority to the Medical Staff to be self-governing and to form its committees freely so that the Medical Staff as a professional body might review its members' competence and make recommendations to the Board of Directors for official action. The intent of this delegation of authority is to promote the continual advancement of health care.

### 1.4. Definitions

- A. The term "**Allied Health Professionals**" (AHP) are those individuals who possess a license, certificate or other legal credential required by Ohio law to provide direct patient care, but who are not practitioners or house staff.
- B. The term "**Advanced Practice Nurse**" (APN) refers to a nurse who holds a valid certificate of authority (COA) to practice in the state of Ohio. He/She enters into a standard care arrangement (SCA) with an attending physician or practitioner who is in a Nationwide Children's Hospital approved ACGME accredited fellowship program or pediatric surgery residency program, and who is under the supervision of an attending physician with whom the APN maintains a CSA and collaborative practice. He/she practices within the knowledge, skills and abilities of her/her education and training in accordance with the standard care arrangement and job description. An APN may or may not have a certificate to prescribe.

The Advanced Practice Nurse includes the Certified Nurse Practitioner (Pediatric and Adult Nurse Practitioner, Family Nurse Practitioner, Family Planning/Gynecology Nurse Practitioner, Neonatal Nurse Practitioner), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA) and other qualified APNs.

- C. The term "**Associate Scientific Staff**" means those professionals who are not so licensed to be Medical Staff but who are degreed as a Doctor of Philosophy, Science or Pharmacy and who are employed or under contract to the Hospital.

- D. The term "**attending physician**" shall refer to that practitioner who has primary responsibility for the patient.
- E. The term "**Board of Directors**" means the governing body of the Hospital. The Board of Directors' Executive Committee shall be called the "Executive Committee of the Board of Directors".
- F. The term "**Chief Executive Officer**" means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital.
- G. The term "**Chief Medical Officer**" means the individual appointed by Nationwide Children's Hospital to be responsible for the clinical work, medical education and quality of patient care delivered throughout Nationwide Children's Hospital and its related companies.
- H. The term "**clinical privileges**" or "**privileges**" means the permission granted by the Board of Directors to Medical Staff which defines the rights and responsibilities to render specific diagnostic, therapeutic, medical and other clinical services to patients of the Hospital.
- I. The term "**collaborating physician**" refers to one or more physicians with whom an APN has entered into a standard care arrangement. These physicians are continuously available to communicate with the APN on patient management activities either in person, telephone, or other form of telecommunication.
- J. The term "**credentialed person**" means that person credentialed by the Hospital Medical Staff and Board of Directors.
- K. The term "**demonstrated current competence**" means and is indicated by the consideration of the following factors as applicable:
1. Practical knowledge of relevant medical principles;
  2. Treatment skills sophistication;
  3. Accuracy and appropriateness of performance and decisions;
  4. Verification of information;
  5. Specialty board certification or memberships;
  6. Participation in continuing education programs;
  7. Publication of articles and books related to areas of expertise;
  8. Presentations as a speaker or leader at educational seminars;
  9. Awards or other special recognition;

10. Current license, licensure history and malpractice claims experience;
11. Observance of Board and Medical Staff Bylaws, Rules/Regulations and Manuals;
12. Participation in peer activities;
13. Peer recommendations and reviews;
14. Outcome of periodic performance appraisals;
15. Outcome of clinical department, program or other monitoring reviews;
16. Results of monitoring clinical performance through quality assessment mechanisms.
17. Proficiency in the following areas:
  - a. patient care;
  - b. medical/clinical knowledge;
  - c. practice-based learning and improvement;
  - d. interpersonal and communication skills;
  - e. professionalism; and
  - f. systems-based practice.

- L. The term “**Dentist**” means an individual who has received a Doctor of Dentistry (D.D.S.), Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery degree; who is currently licensed to practice dentistry in the State of Ohio; and whose practice is in the area of oral and maxillofacial surgery, general dentistry or a specialty thereof.
- M. The term “**General Staff**” means all Medical/Surgical Staff and Allied Health Professionals.
- N. The term “**Hospital**” means Nationwide Children’s Hospital and all its clinical departments, programs, and services.
- O. The term “**Manual**” as used in the Bylaws Manual, Credentials Manual, Organizational Manual, Rules and Regulations Manual and Practitioner Effectiveness Manual shall be deemed to mean “policy.”
- P. The term “**medical-administrative officer**” means a practitioner or other professional, employed by or otherwise serving the Hospital on a full or part time basis whose duties include certain responsibilities which are both administrative and clinical in nature.
- Q. The term “**medical care**” means that care provided by credentialed persons as defined by these Bylaws.

- R. The term "**Medical Executive Committee**" is the Executive Committee of the Medical Staff.
- S. The term "**medical record or medical chart**" refers to documents that exist in either electronic or hardcopy (paper) versions.
- T. The "**Medical Staff**" means all persons who have been licensed to practice allopathic or osteopathic medicine and surgery, dentistry, podiatry or psychology and who have been granted clinical privileges by the Hospital Board of Directors.
- U. The term "**Medical Staff year**" means the period from January 1 to December 31 of each year.
- V. The term "**peer review**" shall mean appraisal and evaluation activities conducted preferably by a staff member(s) with the same specialty as an applicant or member. The purpose of such review activities shall be to evaluate and to provide a knowledgeable appraisal of the individual's qualifications and performance to assist in the development of recommendations pursuant to the Bylaws, Rules/Regulations and Manuals.
- W. The term "**Podiatrist**" means an individual who has received a Doctor of Podiatric Medicine degree and who is currently licensed to practice podiatry in the State of Ohio.
- X. The term "**Practitioner**" means a person licensed to practice allopathic or osteopathic medicine or surgery, podiatry, psychology or dentistry and granted privileges by the Hospital.
- Y. The term "**Psychologist**" means an individual with a doctoral degree in psychology or school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who is currently licensed to practice psychology.
- Z. The term "**standard care arrangement**" is a written guide between the advanced practice nurse and the physician(s) for planning and evaluating the patient's health care.
- a.a. The number and gender of words used in these Medical Staff Manuals are interchangeable.

### **1.5. Name**

The name of this organization shall be the Nationwide Children's Hospital Medical Staff.

### **1.6. Purpose**

The purposes of this organization are:

- A. To provide for appropriate oversight of the care provided to patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive the best possible care;
- B. To promote a high level of professional performance of all persons authorized to practice in the Hospital, or in any of the facilities, departments, or services of the Hospital, through the appropriate delineation of clinical privileges that each person may exercise in the Hospital, or in any of the facilities, departments, or services of the Hospital and through an ongoing review and evaluation of each practitioner's performance;
- C. To provide an appropriate environment which will encourage medical education and clinical and basic research, and that will lead to the continuous advancement in professional knowledge and skill;
- D. To initiate and maintain bylaws, manuals, and rules and regulations for self-government of the Medical Staff; and
- E. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board of Directors, the Chief Medical Officer and the Chief Executive Officer.

## **1.7. Membership**

### **1.7.1. Nature of Membership**

Membership on the Medical Staff of Nationwide Children's Hospital is a privilege which shall be extended only to professionally competent persons who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

### **1.7.2. Qualifications for Membership**

- A. Only practitioners, podiatrists and psychologists licensed to practice in the State of Ohio, who can document their background, training, demonstrate current competence, experience, adherence to the ethics of their profession, good reputation, ability to work with others, and who have not been rejected for appointment or reappointment to the Nationwide Children's Hospital Medical Staff within the previous 12 months shall be qualified for membership on the Medical Staff.
- B. Members of Retired and Emeritus Medical Staff categories shall not be required to have a license to practice since those categories are maintained for honorary positions and for those who have retired from active Hospital practice.
- C. No person shall be entitled to membership on the Medical Staff or to exercise particular clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice his profession in this or in any other state, or that he/she is a member of some professional organization, or that he/she had in the past, or presently has, such privileges at another Hospital. No applicant shall be denied Medical Staff membership and/or clinical privileges on the basis of sex, race, creed, color, religion, sexual orientation, national origin, disability or on the basis of any other criterion lacking professional justification.
- D. Each person applying for privileges (initial and reappointment) must also comply with the applicable Board certification and recertification requirements set forth in Article 2.
- E. Each person applying for privileges shall provide proof of Professional Liability Insurance and maintain in force such coverage during membership on the medical staff. The minimum amount required is no less than \$1 million per incident and \$1 million per annual aggregate. The amount required is determined by the Medical Executive Committee and approved by the Board of Directors.
- F. Acceptance of membership on the Medical Staff shall constitute the member's agreement that he/she will strictly abide by the principles of ethics of his professional society, the Hospital policies and rules, the Hospital's corporate integrity plan and standards of conduct, the standards of practice acceptable to the medical community, and by the Bylaws, Rules/Regulations, and Manuals of the Medical Staff.

- G. By making application to the Medical Staff, the applicant thereby waives any and all rights of personal redress he/she might otherwise obtain against the Hospital or any member of its staff arising out of any action adverse to the applicant taken under these Bylaws and thereby signifies his/her willingness to appear for any interviews in regard to his application, and by making application, he/she authorizes the Hospital and its staff to consult with any person who may have information bearing on his/her competence, character, moral, ethical, professional and personal qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of such qualifications and his competence to carry out the clinical privileges he/she requests, as well as of his moral, ethical and personal qualifications for staff membership. By making application, the applicant further agrees to execute whatever releases may be requested of him by the Hospital or members of its Medical Staff exonerating them or any one of them from liability arising out of their acts provided the Hospital or members of its staff do not act on the basis of false information knowing such information to be false in connection with the evaluation of the applicant and his credentials, and the applicant does, by making application, release from liability all individuals and organizations who provide information to the Hospital provided such individuals and organizations do not provide false information knowing the information to be false concerning the applicant's competence, morals, ethics, character and other qualifications for Medical Staff appointment and clinical privileges.
- H. Upon acceptance of appointment to the Medical Staff, a person thereby waives any and all rights of personal redress he/she may then or in the future obtain against the Hospital or any member of its staff for any adverse action, taken by the Hospital or any member of its staff or any of its committees, at any time during his/her membership on the Medical Staff provided the Hospital or members of its staff or any of its committees do not act on the basis of false information knowing such information to be false. Acceptance of appointment signifies his willingness on a continuing and ongoing basis to appear for interviews in regarding to his/her application or the continuance of his clinical privileges, and authorizes the Hospital and its staff to consult with any person who may have information bearing on his/her competence, character, morals and ethical qualifications. By acceptance of appointment, such person consents to the Hospital's inspection of all records and documents that may be material to its continuing evaluation of his professional qualifications and competence to carry out the clinical privileges he/she has been afforded, as well as of his moral, ethical, professional or personal qualifications for staff membership. By acceptance, such person agrees to execute whatever releases may be requested by the Hospital or members of its staff exonerating them or any of them from liability arising out of their acts provided the Hospital or members of its staff do not act on the basis of false information knowing such information to be false in connection with the evaluation of the person and his/her credentials. Acceptance of such appointment, thereby releases from liability all individuals and organizations who provide information to the Hospital provided such individuals and organizations do not provide false information knowing the information to be false concerning the applicant's competence, morals, ethics, character and other qualifications for continuing staff membership and clinical privileges.

### **1.7.3. Process for Credentialing, Appointment/Reappointment, and Privileging**

Except where the type of privileges being granted allow for an expedited process as set forth in the Bylaws or the Credentials Manual (i.e. Temporary Privileges), the process for credentialing, appointment/reappointment, and privileging shall be as follows:

- A. Applications for appointment, reappointment, and/or privileges shall be submitted to the Medical Staff President through the Medical Staff Office who shall review each application for completeness and perform primary source verification.
- B. Upon completion of the collection and verification process, the completed application and all supporting documents shall be reviewed by the applicable Department/Section Chief, the Chief Medical Officer, the Credentials Committee, and the Medical Executive Committee.
- C. Initial appointments and reappointments to the Medical Staff and/or the granting/regranting of privileges shall be made by the Board, or as otherwise provided in accordance with the Bylaws and Credentials Manual.
- D. The Board shall act on appointments, reappointments, and/or privileges only after there has been a recommendation from the Medical Executive Committee, unless otherwise authorized by these Bylaws or the governing documents of the Hospital.
- E. The detailed procedures for credentialing, for evaluating applications for initial appointment to the Medical Staff, for conducting appraisals for reappointment to the Medical Staff, and for the delineation, granting and re-granting of privileges are outlined in the Credentials Manual.

### **1.7.4. Conditions and Duration of Appointment**

- A. Appointments to the Medical Staff shall be made by the Board of Directors. The Board of Directors shall act on all appointments pursuant to the recommendation from the Medical Staff as provided for in these Bylaws. In the event of unwarranted administrative delay on the part of the Medical Staff, the Board of Directors may act without such recommendation on the basis of evidence of the applicant's moral and ethical qualifications and demonstrated current competence, obtained from reliable sources other than the Medical Staff.
- B. Revocation of appointments, non-reappointments, or other corrective action taken pursuant to Article 2 of the Credentials Manuals, shall be made by the Board of Directors pursuant to recommendation from the Medical Executive Committee, unless the Medical Executive Committee has based its recommendations upon the report of the findings and recommendations of a hearing panel provided for in these Bylaws, in which case the Board of Directors shall be guided by the provisions of Article 4 of the Practitioner Effectiveness Manual. In the event of unwarranted delay on the part of the Medical Executive Committee to act upon the report of the findings and recommendations of the hearing panel, the Board of Directors may act

on the basis of the hearing panel's report of its findings and recommendations or on evidence of the applicant's or staff member's professional, moral and ethical qualifications obtained from sources other than the hearing panel or the Medical Executive Committee.

- C. Acceptance of membership on the Medical Staff shall constitute the member's agreement to provide continuous care and supervision of his/her patients or otherwise arranges a suitable alternate for such care and supervision, to accept committee assignments, to accept consultation assignments, to participate in staffing the Emergency Department, ambulatory care areas and other special care units as requested, and to subject his/her clinical performance to, and participate in, the Hospital's peer review and quality assurance programs.
- D. Initial appointments shall be for a period of one year but not to exceed two years. Reappointments shall be for a period of not more than two (2) Medical Staff years.
- E. Appointments to the Medical Staff shall confer on the applicant only such privileges as are specified in the notice of appointment, or reappointment, in accordance with the Credentials Manual.
- F. Individual staff members who employ allied health professionals shall be responsible for the actions of the employee.
- G. All members of the Medical Staff, including those that are granted temporary privileges, are required to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

#### **1.7.5. Assessments and Dues**

- A. The Medical Executive Committee shall have the authority to determine the amount of assessments or annual dues.
- B. Initial applicants will be assessed a non-refundable processing fee upon submitting an application for clinical privileges and membership to Nationwide Children's Hospital. Failure to pay such fee will result in delay of processing the application.
- C. Annual dues shall be paid by members of the Active I, Active II, Administrative, Postgraduate and Affiliated staff categories. Payment of dues must be submitted to the Medical Staff Office on or before April 1 of each year. Failure to render payment may result in termination from the Medical Staff.

### **1.7.6. Burden of Producing Information**

In connection with all applications for initial appointment and reappointment, the practitioner shall have the burden of producing information for a proper evaluation of the practitioner's experience, background, training, demonstrated ability, and physical and mental health status, and of resolving any doubts about these or any of the other qualifications for staff membership or for a specific staff category or clinical privileges.

## **1.8. Clinical Privileges**

Every person practicing at this Hospital, by virtue of Medical or General Staff membership, shall in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Directors, except as provided in Article 2, section 2.4. Emergency Privileges and section 2.6. Temporary Privileges and except as granted by the Medical Executive Committee as to Associate Scientific Staff.

### **1.8.1. Clinical Privileges - Practitioners**

- A. Every initial application for staff appointment must contain a request for the particular clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, references, and other relevant information, including an appraisal by the clinical department in which such privileges are sought. Each applicant must meet the appropriate departmental training requirements for membership and must have a minimum of two years formal post-graduate training in an accredited institution. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.
- B. Clinical privileges recommended for the practitioner by the department and/or section chief(s) shall be limited to the specific area of expertise as delineated by the national specialty boards in which the practitioner has completed training.
- C. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon, but not limited to, the direct observation of care provided, review of the records of patients treated in this Hospital, and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.
- D. In order to obtain additional clinical privileges, a staff member shall make written application to the Medical Staff Office which must state the type of clinical privileges desired and recent special training and experience. Appropriate documentation must accompany the request. Such application shall be referred to the appropriate department and/or section chief(s), Surgeon-in-Chief (if applicable), and the Chief Medical Officer for action.

### **1.8.2. Clinical Privileges - Podiatrists**

- A. Qualifications and Nature of Privileges

Podiatrists who are appropriately licensed and qualified may be granted clinical privileges that are based upon their documented training, including successful completion of a three year residency and Board eligible or certified status by the standards of the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics, experience, and demonstrated current competence.

Only podiatrists licensed to practice in the State of Ohio, who can document their background, training, demonstrated current competence, pediatric experience, adherence to the ethics of their profession, good reputation and ability to work with others shall be qualified to apply for clinical privileges. Every application for podiatric clinical privileges must contain a request for the particular clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, references, and other information.

B. Application Process

Applications for clinical privileges by podiatrists will be processed in the same manner as is utilized for practitioners seeking appointment to the Medical Staff under Article 2, section 2.1. Appointment Process. The Chief of the Department of Orthopaedics, shall be the appropriate individuals to make such review and recommendation to the Credentials Committee.

C. Conditions and Duration of Privileges

A podiatrist who applies for and is granted clinical privileges agrees that he/she will strictly abide by the principles and ethics of his/her professional society, the standards of practice acceptable in the community, the Hospital policies and rules, and the Bylaws, Rules/Regulations, and Manuals of the Medical Staff.

Acceptance of clinical privileges shall constitute the podiatrist's agreement to provide care and service to his/her patients, to accept consultation assignments, and to subject his performance to, and participate in, the Hospital's quality assurance programs.

D. Reappointment of Clinical Privileges

Any podiatrist seeking to retain his/her clinical privileges must complete a reappointment form. The reappointment request shall be processed in accordance with the terms and procedures contained in the Credentials Manual.

The podiatrist's request for reappointment of privileges shall be processed through the Credentials Committee, biennial. The Chief of the Department of Orthopaedics, shall be the appropriate individuals to make such review and recommendation to the Credentials Committee.

E. Change of Clinical Privileges

A podiatrist wishing to change his/her delineation of clinical privileges must make such a request in writing to the Medical Staff Office and include in such request the reasons for it. Appropriate documentation must accompany the request. The request shall be referred to the department and/or section Chief(s), Surgeon-in-Chief and Chief Medical Officer for action. Thereafter, the procedure outlined under Article 2, section 2.2. Reappointment Procedure, will be followed.

A change in a podiatrist's clinical privileges can be initiated by the Chief of the Department of Orthopedics. Appropriate documentation must accompany the request. The request shall be referred to the Surgeon-in-Chief and the Chief Medical Officer for action. Thereafter, the procedure outlined under Article 2, section 2.2. Reappointment Procedure, will be followed.

F. Terms and Conditions of Podiatric Patient Care

Podiatrists may admit the patient. If the podiatrist admits the patient, the podiatrist must have made prior arrangements with a physician who is medically responsible for that patient's non-podiatric care. All patients admitted for podiatric care shall receive the same medical appraisal as other Hospitalized patients. The physician shall be responsible for the history and physical and medical care that may be required at the time of admission or that may arise during Hospitalization.

The podiatrist shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.

Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief, Department of Orthopaedics. Podiatrists may write orders and prescribe medications within the limits of their licensure and clinical privileges and of the Medical Staff Bylaws, Rules/Regulations, and Manuals.

**1.8.3. Clinical Privileges - Psychologists**

A. Qualification and Nature of Privileges

Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists who satisfy the following minimum qualifications may be granted clinical privileges:

1. a current license to practice psychology issued by the Ohio Board of Psychology; and
2. a Ph.D. in psychology; and
3. satisfactory completion of a minimum of either a one year pre-doctoral pediatric inpatient psychology internship or satisfactory completion of a one year post-doctoral Hospital-based pediatric psychology internship.

Any psychologist who meets these minimum qualifications and who is employed by the Hospital or a corporately related organization, or whose employment by such entities is contingent only upon approval of privileges pursuant to the Bylaws, Rules/Regulations and Manuals shall be eligible to apply for clinical privileges. No applicant will be denied privileges because of the nature of the specialty.

B. Application Process

Applications for clinical privileges by psychologists will be processed in the same manner as is utilized for practitioners seeking appointment to the Medical Staff under Article 2, Section 2.1. Appointment Process. The Chief of the Section of Psychology, after consultation with the Chief, Department of Pediatrics, shall make such review and recommendation.

C. Conditions and Duration of Privileges

Clinical privileges shall be granted for a least one (1) year and shall not exceed two (2) years after initial issuance of privileges. During this time, the psychologist shall be under the supervision of a member of the Medical Staff as designated by the appropriate section/department chief(s). Granting of clinical privileges shall confer on the psychologists only such privileges as are specified in the notice of approval or reappointment in accordance with the Bylaws, Rules/Regulations and Manuals.

D. Reappointment of Clinical Privileges

Any psychologist seeking to retain his/her clinical privileges must complete a reappointment form and submit payment of annual dues to the Medical Staff Office by June 30th of the second year of the reappointment term.

Failure to file a completed form and annual dues on or before said date may result in termination of clinical privileges. Proof of professional liability insurance, in an amount designated by the Board of Directors, must also accompany the reappointment form.

E. Change of Clinical Privileges

A psychologist wishing to change his/her delineation of clinical privileges must make such a request in writing to the appropriate department and/or section chief(s) and include in such request the reasons for it.

Thereafter, the procedure outlined under Article 2, section 2.2, Reappointment Procedure, will be followed. A change in a psychologist's clinical privileges can be initiated by the Chief of the Department of Pediatrics, by submitting such a request in writing to the Credentials Committee. Thereafter, the procedure outlined under Article 2, section 2.2. Reappointment Procedure, will be followed.

F. Terms and Conditions of Patient Care by Psychologists

Psychologists may not admit patients. A practitioner of the Medical Staff shall admit the patient. A psychologist must have prior approval from the admitting practitioner who is medically responsible for that patient. All patients admitted for psychological care shall receive the same medical appraisal as other Hospitalized patients. The practitioner shall be responsible for the history and physical and medical care that may be required at the time of admission or that may arise during Hospitalization.

The psychologist shall be responsible for the psychological care of the patient including the psychological history and all appropriate elements of the patient's record. Any psychological care performed by a psychologist must be under the supervision of the appropriate section/department chief(s). Psychologists may practice within the limits of their licensure and clinical privileges and the Medical Staff Bylaws, Rules/Regulations, and Manuals.

## **1.9. Confidentiality of Credential Files and Minutes**

### **1.9.1. Files and Committees**

- A. The following applies to Medical Staff credentials files and committees responsible for the evaluation of any Medical Staff member, applicants for Medical Staff membership or practitioners applying for or holding clinical privileges (hereinafter collectively referred to as “Practitioners”).
- B. Information with respect to any practitioner that is submitted, collected, or prepared by any representative of Nationwide Children’s Hospital or any other health care facility, organization, or Medical Staff for the purpose of achieving and maintaining the quality of patient care, and provided to the Credentials Committee or such other committee whose purpose it is to review and access quality information or otherwise perform quality improvement functions, shall to the fullest extent permitted by law, be held in confidence and not be disseminated except as provided herein or except as otherwise required by law.
- C. Any committee as described above shall be considered a review committee as described in Ohio Revised Code Section 2305.24 and 2305.25.
- D. A breach of confidentiality by any Medical Staff representative would include but not be limited to the release or exchange of any oral or written information to any person/group/agency and may violate provisions of the Ohio Revised Code, imposing civil liability. If it is determined that such a breach has occurred, the individual found to violate this policy may be subject to corrective action as deemed appropriate.
- E. Subject to section 1.9.2. herein below, dissemination of information contained in credential files and committee minutes shall require a subpoena. All subpoenas shall be referred to the Legal Services Department. The Legal Services Department will advise and consult with the Medical Staff President and the Chief Medical Officer regarding the particular situation.

### **1.9.2. Access to Credentials Files**

- A. The following individuals shall be authorized representatives to have access to Medical Staff credentials files to the extent necessary to perform official functions, and subject to the requirement that confidentiality be maintained:
  - 1. Medical Staff Office Personnel
  - 2. Respective Section/Department Chief(s)
  - 3. Officers of the Medical Staff
  - 4. Chief Medical Officer
  - 5. Surgeon-in-Chief
  - 6. Physician-in-Chief
  - 7. Credentials Committee Chair

8. Chair, CHPHN Credentials Committee
  9. Chair, Surgery Center Medical Advisory Committee
  10. Legal Counsel for Nationwide Children's Hospital
  11. Credentials Committee Chair of related organizations which have contracted with Nationwide Children's Hospital for credentialing and peer review-related services
  12. Any person authorized in writing by the practitioner about whom the credentials file relates.
- B. The authorized representatives shall have viewing access only in the presence of Medical Staff Office personnel and will not be allowed to remove the credential files from Hospital premises.
- C. A practitioner will be permitted access to all information in the practitioner's credentials file submitted by the practitioner. A practitioner shall not have access to materials that include evaluations or other information that has been deemed restricted by the Credentials Committee. A practitioner shall be given access to such information during the course of a fair hearing if an adverse action or recommendation is based on such information.
- D. Subject to the access rights described hereinabove, information contained in the credential files of any practitioner may be disclosed only with the written consent of the practitioner.
- E. Requests for credentialing information from external organizations shall be in writing, include the reasons for the information and a statement signed by the practitioner releasing from liability all those providing the information
- F. Requests for clinical evaluation, restriction of privileges or adverse actions will be referred to the respective section/department chief(s) for completion along with a signed release from the practitioner.
- G. No information will be released by telephone except for confirmation of the practitioner's name and respective department and/or section chief(s).
- H. Accreditation surveyors shall be entitled to inspect Medical Staff credential files on the Hospital premises in the presence of Medical Staff Office personnel.
- I. Individuals representing managed care organizations shall have limited access to the Medical Staff credential files, in the presence of Medical Staff Office personnel, with a signed release from the practitioner. Documents contained in the files are viewable only and cannot be copied. The Managed Care Department will negotiate minimum contractual provisions with the health plans that will provide constraints for these reviews and protect the confidentiality of sensitive practitioner information.

### **1.9.3. Location and Security Precautions**

- A. All Medical Staff credential files shall be maintained in the Medical Staff Office. Such files shall be secured and under the supervision of the Executive Assistant for Medical Staff Services. The files shall be secured except during such times as the Medical Staff Office personnel are physically present and able to monitor access.
  
- B. Medical Staff credential files will not be removed from the Medical Staff Office unless under the supervision of Medical Staff Office personnel.

### **1.9.4. Medical Staff Committee and Department/Section Minutes**

- A. Dissemination of Medical Staff committee minutes, or department and/or section minutes (as defined in the Medical Staff Bylaws, Rules/Regulations and Manuals), related documents, and appendages shall only be made where expressly required by law.
  
- B. Access to minutes by persons performing official Hospital or Medical Staff functions shall be permitted only to the extent necessary to perform said functions upon approval of the Medical Staff President.
  
- C. Provisions shall be taken to protect all peer review and monitoring minutes from disclosure as follows:
  - 1. Minutes shall be restricted to those actually involved in the review process.
  
  - 2. Minutes distributed at a meeting may be collected at the conclusion of a meeting. Otherwise, it is the committee member's responsibility to maintain confidentiality of all minutes.
  
  - 3. Minutes shall be stamped "Confidential Quality Assurance Information Protected by Law" under Ohio Revised Code 2305.24 and 2305.25.
  
- D. Accreditation surveyors shall be entitled to inspect Medical Staff committee minutes or department and/or section minutes in the presence of Medical Staff Office personnel.

## **1.10. Professional Conduct and Practitioner Competency**

### **1.10.1. Professional Conduct**

Practitioners having privileges pursuant to these Medical Staff Bylaws, Rules/Regulations and Manuals are expected to conduct themselves in a professional and courteous way so as to reflect a respect for the rights of others and foster quality patient care. Actions of practitioners that fall below accepted standards of professional conduct or courtesy will be considered misconduct and will not be tolerated. This shall include conduct which has the purpose or effect of interfering with an individual's work performance, interfering with Hospital activities or creating an intimidating, hostile or offensive work environment.

### **1.10.2. Practitioner Competency**

Practitioners having privileges pursuant to these Medical Staff Bylaws, Rules/Regulations and Manuals shall perform their professional privileges consistent with accepted and prevailing standards of care.

- A. The Hospital's focused professional practice evaluation ("FPPE") process shall be set forth in detail in the Practitioner Effectiveness manual and shall be implemented for all: (1) practitioners requesting initial privileges and, (2) existing practitioners requesting privileges during the course of an appointment period. The FPPE period shall be used to determine the practitioner's current clinical competence and ability to perform the requested privileges.
- B. Upon conclusion of the FPPE period, an ongoing professional practice evaluation ("OPPE") shall be conducted on all practitioners with privileges. The Hospital's OPPE process shall be set forth in detail in the Practitioner Effectiveness manual and requires the Hospital to gather, maintain and review data on the performance of all practitioners with privileges on an ongoing basis, rather than bi-annually at the time of reappointment, to allow the practitioner to take steps to improve his/her performance on a more timely basis.

### **1.10.3. Informal Process**

Whenever the professional conduct of any practitioner, including those with temporary privileges, may be considered to be in violation of any of the above-described statements regarding professional conduct or practitioner competency, and as such may adversely affect the quality of care or be disruptive to the operations of the Hospital, and attempts to resolve the concern between the individuals themselves or with the involvement of supervisors have been unsuccessful, then there shall first be an attempt to resolve the concern informally in accordance with the following procedure.

- A. This informal process may be initiated by the complainant notifying the Vice President of the Medical Staff of the nature of the concern and the basis allegedly supporting it.

In the event the Vice President is the involved person, the review and report shall be performed by the Medical Staff President. The Vice President may in his/her discretion involve other Officers and/or the Chief Medical Officer, to aid in any of the steps described in this Article.

- B. The Vice President of the Medical Staff shall then meet with the member about whom the concern is raised to discuss the concern and seek a mutually agreeable resolution. This meeting may include the individual(s) who raised the concern at the discretion of the Vice President of the Medical Staff. Part of the Vice President's assessment may include a review of any existing personnel files of the practitioner about whom the concern is raised and/or consultation with the Professional Review Committee as appropriate.
- C. At the conclusion of this informal process, the Vice President shall make a recommendation to the Medical Staff President. The Medical Staff President shall confer with the Chief Medical Officer and the Chief Executive Officer as appropriate, before determining a course of action which may include (a) closure of the review for lack of sufficient supportive evidence; (b) a verbal warning; (c) a letter of reprimand; (d) a requirement for professional evaluation and/or treatment or referral to the Practitioner Health process; (e) referral for formal review or investigation; and/or (f) such other assistance, counseling, rehabilitative services or reasonable accommodations as may be appropriate under the circumstances.
- D. The affected practitioner shall be advised by the Vice President of the Medical Staff of the resolution or course of action determined.
- E. The informal process shall be documented. Written documentation shall be maintained in the respective practitioner's file and the Medical Staff Office. The practitioner may submit his/her own written explanation which shall also be maintained in that file. If it is determined that there is insufficient merit to the allegation, the written documentation will be forwarded to the Nationwide Children's Hospital Legal Services and will be maintained in a privileged and confidential file.

#### **1.10.4. Formal Process**

- A. If the informal procedure described in section 1.10.3. hereinabove fails to resolve the concern to the satisfaction of the Medical Staff Vice President a formal professional review may be initiated.
- B. Such requests shall consist of a written statement of the nature of the concern and be supported with a description of the specific activities, events or conduct constituting the reasons for the requested review.

C. The written request may be submitted to the appropriate department and/or section chief(s), the Chief Medical Officer, the Chief Executive Officer or any Medical Staff Officer. A copy of the written request shall be directed to the Vice President of the Medical Staff. The Vice President of the Medical Staff shall promptly notify the President of the Medical Staff in writing of the request received.

In turn, the Medical Staff President shall promptly notify Chief Medical Officer, the Chief Executive Officer, and the affected member's department chief in writing of the request and continue to keep them fully informed of all action taken in connection therewith.

D. The Vice President of the Medical Staff shall forward any request for formal review to the chief of the involved member's department.

E. Upon receipt of such request, the chief of the department shall confer with the appropriate section chief, if any, and they shall promptly review the issue(s) or designate an ad hoc committee to conduct the review. The review shall include, but not necessarily be limited to, an interview with the member who is the subject of the request and the individual who raised the concern. Any such interview shall not be regarded as a hearing and may also include a review of any existing personnel files of the affected member.

F. The review should be completed and a report submitted within thirty (30) days of the receipt of request for review by the department chief. If this guideline cannot be met, the chief shall provide the reasons(s) to the Vice President of the Medical Staff.

G. Upon completion of the review, the department chief shall promptly make a report to the Vice President of the Medical Staff.

H. In the event the concern involves someone involved in the formal process, such review shall be performed by the individual's superior.

I. Pursuant to receipt of the report from the department chief, the Vice President shall confer with the officers of the Medical Staff. The Officers of the Medical Staff will then determine a recommended course of action which may be:

- (1) closure of the investigation for lack of sufficient supportive evidence;
- (2) a verbal warning;
- (3) a letter of reprimand;
- (4) a requirement for professional evaluation and/or treatment or referral to the Practitioner Health process;
- (5) referral for investigation; and/or
- (6) such other assistance, counseling, rehabilitative services or reasonable accommodations as may be deemed appropriate.

- J. The Vice President of the Medical Staff shall communicate the recommendations of the Officers of the Medical Staff to both the complaining party and the member in question and in a manner consistent with any applicable peer review protection privilege the individual(s) who raised the concern shall be provided general information.
- K. The President of the Medical Staff shall be responsible for carrying out these recommendations.
- L. The formal process shall be documented. Written documentation shall be maintained in the respective practitioner's file and the Medical Staff Office. The practitioner may submit his/her own written explanation which shall also be maintained in that file. If it is determined that there is insufficient merit to the allegation, the written documentation will be forwarded to the Nationwide Children's Hospital Legal Services and will be maintained in a privileged and confidential file.

#### **1.10.5. Professional Review Committee**

If the Medical Staff informal and formal review processes fail to resolve the concern in the judgment of the Medical Staff Officers, then any Medical Staff Officer may request that the Professional Review Committee be convened to investigate the issue(s).

- A. Upon written request of the Medical Staff Officers, the Medical Staff President shall promptly convene the review panel.
- B. The Professional Review Committee shall consist of members of the Medical Staff appointed by the President of the Medical Staff, an administrative representative and an individual representing the complainants' area both to be appointed by the Chief Executive Officer and the Chief Medical Officer. In the event the individual(s) who raised the concern and the involved member are both members of the Medical Staff, the Professional Review Committee shall consist of two members of the Medical Staff appointed by the Medical Staff President and an administrative representative appointed by the Chief Executive Officer and the Chief Medical Officer.
- C. The Professional Review Committee shall investigate these charges. The investigation shall include an interview with the affected member and the individual(s) who raised the concern and may include review of files.
- D. Upon completion of the investigation, the Professional Review Committee shall promptly make a report to the Medical Staff President.
- E. The Professional Review Committee shall recommend to the Medical Staff President:

1. The closure of the investigation for lack of sufficient evidence;
  2. A verbal warning;
  3. A letter of reprimand;
  4. A requirement for professional evaluation and/or treatment or referral to the Practitioner Health process;
  5. A reduction, suspension or revocation of clinical privileges;
  6. A suspension from the Medical Staff;
  7. Such other assistance, counseling, rehabilitative services or reasonable accommodations as deemed appropriate.
- F. The Medical Staff President will be responsible for carrying out these recommendations and notifying the Chief Medical Officer and the Chief Executive Officer.
- G. If the recommendations of the Professional Review Committee, or the recommendations of the Officers of the Medical Staff (if the Review Committee is not convened) may adversely affect the clinical privileges or staff membership of the affected member, (e.g. reduction, restriction, suspension or revocation of privileges or membership) that recommendation must be submitted by the President of the Medical Staff to the Medical Executive Committee for action.
- H. If the action of the Medical Executive Committee may adversely affect the clinical privileges or staff membership of the affected practitioner, he/she shall be entitled to a hearing pursuant to the Medical Staff Bylaws Manual.
- I. The Professional Review Committee process shall be documented. If the final outcome of all proceedings, including a hearing, if one is held, is anything other than no merit to the allegations, all written documentation shall be maintained in the respective practitioner's file in the Medical Staff Office.
- J. If the final outcome of all proceedings, including a hearing, if one is held, is that of no merit to the allegations, all written documentation will be forwarded to Nationwide Children's Hospital Legal Services and will be maintained in privileged and confidential file.

### **1.10.6. Precautionary Suspension or Restriction of Clinical Privileges**

- A. Whenever in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the following individuals shall have the authority to:
  - 1. suspend or restrict all or any portion of an individual's clinical privileges and
  - 2. afford the individual opportunity to voluntarily refrain from exercising privileges pending an investigation:
    - a. the Chief Medical Officer or a designee, in consultation with the Medical Staff President or a designee;
    - b. the Physician-in-Chief or a designee, in consultation with the Chief Medical Officer and the Medical Staff President or their designees; or
    - c. the Surgeon-in-Chief or a designee, in consultation with the Chief Medical Officer and the Medical Staff President or their designees.
- B. A precautionary suspension or restriction can be imposed at any time, including but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.
- C. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- D. A precautionary suspension or restriction shall become effective immediately upon imposition and shall remain in effect unless it is modified by the Medical Executive Committee as set forth in section 1.10.6(F) below.
- E. The individual in question shall be provided a brief written description of the reasons(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved, if any, within three days of the imposition of the suspension.
- F. Medical Executive Committee Procedure:
  - 1. The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed fourteen (14) days. Prior to, or as part of this review, the individual shall be given an opportunity to meet with the members of the Medical Executive Committee.

The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances. A meeting of the Medical Executive Committee under this section shall in no way be considered a hearing as contemplated in section 1.11. even if the individual involved attends the meeting, and no procedural requirements shall apply.

2. After considering the matters resulting in the suspension or restriction of the individual's response, if any, the Medical Executive Committee shall determine, at a meeting in which a quorum is present in person, whether the precautionary suspension or restriction should be continued, modified, or terminated. The vote will be a majority vote. If the Medical Executive Committee determines that the precautionary suspension or restriction should be continued or modified, the Medical Executive Committee shall advise the individual of his/her rights to a hearing pursuant to section 1.11.
3. Not later than fourteen (14) days following the original imposition of the precautionary suspension, the individual shall be advised of the Medical Executive committee's determination and of the individual's rights to a hearing, if any, pursuant to section 1.11. A precautionary suspension that is lifted within fourteen (14) days of its original imposition shall not be deemed an adverse recommendation for purposes of section 1.11.

#### **1.10.7. Automatic Suspension**

- A. Action by the State Board of Medical or Dental Examiners or other similar state licensing authority revoking, suspending, restricting or being placed on probation a person's license, shall automatically impose the same action upon his/her Hospital privileges without a right to hearing.
- B. Each person who desires to practice medicine or surgery or osteopathic medicine and surgery shall file with the State Board of Medical or Dental Examiners a written application to practice in the year registration is required. Failure to register and comply with Ohio Law shall result in being suspended for failure to renew licensure without a right to hearing. Reinstatement of privileges will be instituted upon receipt of written documentation from the appropriate licensing board.
- C. Action by the Drug Enforcement Administration (DEA) or other controlled substances authority revoking, suspending, restricting, or being placed on probation, shall automatically impose the same action upon his/her Hospital privileges without a right to a hearing. Reinstatement of privileges to prescribe medications covered by the number will be instituted upon receipt of written documentation from the appropriate licensing agency.

- D. Failure to provide proof of current professional liability insurance in an amount not less than \$1 million per incident and \$1 million per annual aggregate within thirty (30) days of request shall result in immediate suspension of all privileges without a right to a hearing. Upon receipt of the appropriate documentation, reinstatement of privileges will be instituted.
- E. Failure to provide documentation of annual PPD skin testing (annual Mantoux PPD skin test) unless the practitioner has a history of a prior positive skin test. Those individuals with a prior skin test will be required to complete a questionnaire concerning symptoms related to tuberculosis. Failure to comply shall result in immediate suspension of all privileges without a right to a hearing. Upon receipt of the appropriate documentation, reinstatement of privileges will be instituted.
- F. Failure to meet or maintain board certification shall result in automatic termination of membership and clinical privileges on the Medical Staff. This amendment will apply to practitioners whose applications are received after July 1, 2005.

All practitioners for membership and clinical privileges shall at the time of appointment or reappointment, be and remain board certified by the national specialty board applicable to their primary specialty/sub-specialty. A practitioner who is a qualified candidate for board certification at the time of initial appointment shall have five years from the date eligibility was first attained to become board certified.

Board certification is a continuing requirement. Whenever recertification is required by a specialty/sub-specialty board(s), practitioners for reappointment shall meet the terms of recertification established by their respective primary specialty/sub-specialty board(s).

- G. Notification of automatic suspension and reinstatement of privileges will be given to the person by the Medical Staff President and Chief Medical Officer in writing.
- H. An administrative suspension for failure to complete medical records or noncompliance with electronic medical records (EMR) policies or regulations, in the form of withdrawal of admitting privileges and/or surgical privileges, as provided for in the Medical Staff Bylaws, Rules/Regulations, and Manuals, may be imposed by the Medical Staff President in conjunction with the Chief Medical Officer until the delinquent medical records are completed or EMR noncompliance corrected. Such administrative suspension shall not give rise to any appeal or hearing rights under the Medical Staff Bylaws Manual.

### **1.10.8. Alternate Medical Coverage During Suspension**

Immediately upon the imposition of a suspension, the Chief Medical Officer, after consultation with the department chief, shall have authority to provide for alternative medical coverage for the patients of the suspended person who remain in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative person.

### **1.10.9. House Staff**

#### **A. Initiation of Request**

Whenever there exists good cause for a warning, restriction or revocation of participation by any individual in a house staff training program, prior to the completion of his/her term, such action may be requested by the supervisor or the teaching attending of the house officer.

The request for such action shall be made in writing to the respective residency program director and the Chief Medical Officer or his/her designee and shall be supported by reference to the specific activities or conduct or omissions which constitute the grounds for the request. The program director shall investigate the charge and follow the defined process.

#### **B. Notice**

In the event the Chief Medical Officer sanctions the house officer, the house officer shall be afforded hearing rights, if any, available pursuant to due process in his/her respective program.

## **1.11. Hearings**

### **1.11.1. Appeals**

- A. In any case where any final recommendation made pursuant to Articles 1, or 2, or 4 would result in adversely affecting the clinical privileges or staff membership of an affected person (other than House Staff) (restriction, reduction, suspension or revocation of privileges or staff membership), the Medical Executive Committee or its designee shall notify the affected person concerned by registered return receipt letter, or by personal delivery with a signed receipt. The notice shall state:
1. the reasons for the adverse recommendation;
  2. that the affected person has the right to request a hearing within thirty days (30) of the date of receipt of the notice;
  3. that if a hearing is requested, the affected person has the right of representation;
  4. a right to the copy of the record of the hearing;
  5. the right to call and examine witnesses;
  6. the right to submit any evidence relevant to the issues, and
  7. the right to submit a written statement at the close of the hearing.
- B. If the affected person requests a hearing, a written notice shall be given to the person stating the time, date and place of the hearing, which date shall be not less than thirty (30) days from the date of notice. If available, the notice shall also state the names of witnesses, if any, expected to testify at the request of the Hospital or Medical Staff. Thereafter a hearing will be held within thirty days. The hearing shall be conducted in accordance with this Article. No adverse recommendation shall be transmitted to the Board of Directors until the affected person has exercised or has waived his right to a hearing. If he/she does not request a hearing within thirty (30) days of the notification, he/she shall be deemed to have waived all right to appeal.

### **1.11.2. Hearing Panel**

- A. The Medical Staff Officers and Chief Medical Officer shall appoint a Hearing Panel in accordance with the following guidelines:
1. The Hearing Panel shall consist of at least three members, one of whom shall be designated as Chair;
  2. The Hearing Panel may include any combination of:

- a. Any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and/or
  - b. Physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital);
3. Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel;
  4. Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel;
  5. The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing;
  6. The Panel shall not include any individual who is professionally associated with, or related to, the individual requesting the hearing, and
  7. The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
- B. In lieu of a Hearing Panel Chair, the Medical Staff President and Chief Medical Officer may appointment a Presiding Officer who may be an attorney. The presiding officer will not act as an advocate for either side at the hearing. If no presiding officer has been appointed, the Chair of the Hearing Panel will serve as the presiding officer and will be entitled to one vote. The presiding officer will:
1. allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
  2. prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
  3. maintain decorum throughout the hearing;
  4. determine the order of procedure;
  5. rule on all matters of procedure and the admissibility of evidence;
  6. conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
  7. participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but will not be entitled to vote on its recommendations.

8. The presiding officer and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.
- C. Any objection to any member of the Hearing Panel or presiding officer must be made in writing, within ten (10) days of receipt of notice, to the Chief Medical Officer. A copy of such written objection must be provided to the Medical Staff President and must include the basis for the objection. The Medical Staff President will be given a reasonable opportunity to comment. The Chief Medical Officer will rule on the objection and give notice to the parties. The Chief Medical Officer may request that the presiding officer make a recommendation as to the validity of the objection.

### **1.11.3. Pre-Hearing Procedures**

A. General Procedures:

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

B. Provision of Relevant Information:

1. Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed business associate agreements in connection with any patient Protected Health Information contained in any documents provided.
2. Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:
  - a. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
  - b. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
  - c. copies of any other documents relied upon by the Medical Executive Committee.
  - d. the provision of this information is not intended to waive any privilege under the state peer review protection statute.
3. The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners.

4. Prior to the pre-hearing conference, on dates set by the presiding officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-hearing conference. The presiding officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.
5. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.
6. Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual will contact Hospital employees appearing on the Medical Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

#### **1.11.4. Hearings**

- A. All three members of the Hearing Panel shall be required to hear the evidence presented at any hearing. The proceeding will be informal in nature and the legal rules of evidence shall be loosely applied as the hearing panel deems appropriate. Any decision adopted by two members of the panel shall be the decision of the panel. The Hearing Panel may request legal counsel to assist it in procedural issues. All expenses of the conduct of any hearing by a Hearing Panel shall be borne by the Hospital.
- B. The Hearing Panel and the affected person may mutually reschedule the date upon which the hearing will be held.
- C. At the hearing, the Medical Executive Committee acting for and on behalf of the Hospital shall be one party and the affected person who made timely request for a hearing shall be the other party. The Medical Executive Committee may designate any one or more of its members to represent it as the party at the hearing. Each party may be present at the hearing, be represented by counsel and may offer any relevant evidence. Each party may call witnesses, cross-examine witnesses called by the other party, introduce exhibits, charts, and medical records and rebut evidence presented by the other party. Each party may be called and examined as if under cross examination. The proceedings shall be recorded and each party may obtain a transcript upon payment of the cost thereof.

Within seven (7) days of the conclusion of the hearing, the Hearing Panel shall report in writing its findings and recommendations to the Medical Executive Committee and to the person who requested the hearing. The report shall include a statement of the reasons for the recommendation(s).

- D. The Medical Executive Committee, upon receipt of the written report of the Hearing Panel, shall determine whether such report was made pursuant to the requirements of the Medical Staff Bylaws, Rules/Regulations, and Manuals and, if it finds such report was so made, transmit such report with its own recommendation, to the Board of Directors within thirty (30) days. In the event the Medical Executive Committee finds error, the matter shall be remanded for reconsideration.
- E. The Board of Directors or its Executive Committee, after review of the materials submitted to it, shall issue its decision with a statement of the reasons for it. The Board of Directors or its Executive Committee has the ultimate responsibility regarding Medical Staff appointment and privilege issues and shall not be required to adopt the recommendation of the Hearing Panel or the Medical Executive Committee.
- F. Within thirty (30) days, notification of the action of the Board of Directors shall be sent by the Chief Executive Officer to the Medical Executive Committee, the appropriate department and/or section chief(s), when applicable to the Chief Medical Officer, and to the affected person who requested the hearing.
- G. In the event the Board of Directors or Executive Committee's decision is contrary to the recommendation of the Hearing Panel, the affected person or the Medical Executive Committee may request an appellate review before a three member panel of Trustees appointed by the President of the Board. The appellate review shall be requested within seven days of receipt of the Board's decision or be forever waived. The purpose of the hearing shall not be the submission of new evidence but rather to allow the affected person to demonstrate why the Board's decision was improper and why the recommendation of the Hearing Panel should be adopted. The Board hearing panel shall hold such review as promptly as feasible and after such review shall report its findings and recommendations to the Board or the Executive Committee. After receipt of the recommendation of the Board hearing panel, the Board or Executive Committee shall issue its decision which shall become the final decision of the Hospital.
- H. In all cases where the affected person does not request a hearing within thirty (30) days of the date upon which the applicant received written notice of the adverse recommendation and his/her right to a hearing, the recommendation of the Medical Executive Committee shall be final and shall be forwarded immediately to the Board of Directors with notification that the applicant waived his/her right to a hearing. The affected person must exhaust all administrative remedies provided by these Bylaws prior to the initiation of any proceeding in law or equity.

## **1.12. Officers/Medical Staff Structure**

### **1.12.1. Officers of the Medical Staff**

- A. The elected officers of the Medical Staff shall be:
  - 1. President
  - 2. Vice-President
  - 3. Immediate Past President
- B. The President shall be nominated to become Immediate Past President immediately following his or her term as President. In the event the incumbent President does not desire to become Immediate Past President, then the Nominating Committee shall nominate another Medical Staff member who has previously held the office of President to serve as a replacement Immediate Past President for election by the Active Medical Staff.

### **1.12.2. Qualifications of Medical Staff Officers**

- A. Officers must be members of the Medical Staff in good standing at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
- B. Elected Officers are expected to facilitate communication and joint decision-making with each other as well as the Hospital Administration in matters of mutual concern.
- C. Elected Officers must attend one continuing education program related to Medical Staff leadership and/or credentialing functions during their term of office.
- D. The Chief Medical Officer, Administrative Medical/Surgical Directors, Physician-In-Chief, Surgeon-In-Chief, and the department chiefs of Pediatrics and Pediatric Surgery are not eligible for election as Medical Staff Officers.

### **1.12.3. Election of Medical Staff Officers**

- A. Officers shall be elected by a majority vote of the Active Medical Staff.
- B. The Nominating Committee shall consist of the Chief Medical Officer and the five most recent past Medical Staff presidents with the Immediate Past President acting as chairperson of the committee.

- C. The current Medical Staff President will serve as a consultant to the Nominating Committee and will not be voting member when selecting the nominees for the slate of Medical Staff Officers, elected representatives and the appointed at-large representative to the Medical Executive Committee.
- D. The Nominating Committee shall receive and consider names of Medical Staff members in good standing for the offices of President, Vice President and Immediate Past President. The Nominating Committee will maintain a balance of leadership representation alternating between medical and surgical specialties for Medical Staff President and Vice-President.
- E. The nominees for the office of President, Vice-President and Immediate Past President shall be submitted to the Medical Executive Committee for information.
- F. The Nominating Committee's nominees for the offices of President, Vice-President and Immediate Past President shall be submitted to the Active Medical Staff for vote.

#### **1.12.4. Term of Office**

Each elected Medical Staff Officer shall serve a two-year term, commencing on the first day of January of the year following the election.

#### **1.12.5. Duties of Medical Staff Officers**

- A. President: The President shall serve as the principal elected Officer of the Medical Staff. The duties shall include but not be limited to the following:
  - 1. Act in coordination and cooperation with the Chief Executive Officer and Chief Medical Officer in all matters of mutual concern within the Hospital;
  - 2. Serve as chairperson and be responsible for the agenda of all General Staff meetings and minutes;
  - 3. Serve as chairperson, voting member, and be responsible for the agenda of all Medical Executive Committee meetings and minutes;
  - 4. Be a voting member of the Joint Conference Committee and any Medical Staff committee to which he/she has been appointed;
  - 5. Be responsible for the enforcement of Medical Staff Manuals; for implementation of sanctions where these are indicated; and for the Medical Staff's compliance with the procedural safe-guards in all instances where corrective action has been requested against a member;

6. Appoint, after consultation with the Chief Medical Officer, committee chairperson and members to all standing, and multidisciplinary Medical Staff committees except the Medical Executive Committee and the Joint Conference Committee;
7. Serve as a consultant to the Chief Medical Officer for appointment of members to integrated committees;
8. Represent the views, policies, needs, and grievances of the Medical Staff to the Chief Medical Officer, Chief Executive Officer and Board of Directors;
9. Be the spokesperson for the Medical Staff in its external professional and public relations;
10. Serve as ex-officio member of the Board of Directors and its Executive Committee; recommend to the Board of Directors appointments, reappointments and other Medical Staff business.

B. Vice-President.

1. In the absence of the President, he/she shall assume all the duties and have the authority of President;
2. Serve on the Hospital Quality Improvement Committee, Chief Medical Officer Advisory Committee, Bylaws Committee, Credentials Committee, and the Medical Executive Committee;
3. Be a voting member of the Joint Conference Committee and any Medical Staff or Board of Directors committees to which he/she has been appointed;
4. Create the Medical Staff budget in consultation with the Manager of Medical Staff Services and the other Medical Staff Officers;
5. Automatically succeed the President when the latter fails to serve for any reason. He/she shall carry out the duties of the President as specified in the Medical Staff Manuals;
6. Perform additional duties as may be assigned by the Medical Staff President;
7. Be responsible for assisting the Medical Staff President in the enforcement of the Medical Staff Manuals.

C. Immediate Past-President.

1. Serve as an advisory and voting member of the Medical Executive Committee to provide continuity of discussions, actions, and programs implemented during his/her term as President;

2. Serve as chairperson of the Nominating Committee;
3. Serve as chairperson of the Bylaws Committee and assist the Medical Staff Officers in creating and revising the Medical Staff Manuals;
4. Serve on the Hospital Quality Improvement Committee, Chief Medical Officer Advisory Committee, and Credentials Committee;
5. Be a voting member of the Joint Conference Committee and any Medical Staff or Board of Directors committee to which he/she has been appointed;
6. Develop and maintain programs for physicians in partnership with relevant Hospital departments, e.g. orientation, mentoring, and wellness;
7. Serve as the OPPE and FPPE consultant for the Medical Staff;
8. Perform additional duties as may be assigned by the Medical Staff President;
9. Be responsible for assisting the Medical Staff President in the enforcement of the Medical Staff Manuals.

#### **1.12.6. Compensation for Medical Staff Officers**

The elected Officers of the Medical Staff (President; Vice-President; Immediate Past President) shall be compensated for their services with funds derived from the Medical Staff Activities fund. The amount of compensation shall be determined by the Medical Executive Committee.

#### **1.12.7. Vacancies in Office**

Vacancies in office during the Medical Staff year, except for the Presidency, shall be filled by the Medical Executive Committee of the Medical Staff. If there is a vacancy in the office of the President, the Vice-President shall serve out the remaining term.

#### **1.12.8. Removal of Medical Staff Officers**

Any Officer may be removed from his or her position by two-thirds of the voting members present at a special meeting of the Medical Staff. Written notification shall be submitted to the Medical Staff at least 10 days prior to the meeting. Removal may be based upon failure to perform the duties of the position held as described in the Medical Staff Manuals or other reasons deemed sufficient by the Medical Executive Committee and/or the Medical Staff.

**1.12.9. Representative to the American Medical Association/Organized Medical Staff Section and the Columbus Medical Association**

- A. The representative to the American Medical Association/Organized Medical Staff Section and the Columbus Medical Association shall be held by one representative for a three year period. The selection process for such position will be determined by the Officers of the Medical Staff.
- B. The duties shall include, but not be limited to the following:
  - 1. Shall be a member of the Medical Staff in good standing;
  - 2. Shall be a member of the Columbus Medical Association;
  - 3. Shall act as a liaison in the political aspects of local, state and national Medical Staff issues.

**1.12.10. Medical Staff Structure**

The Medical Staff has a formalized organizational structure made up of departments and sections as set forth in Section 3.1.2. of the Organizational Manual. Each department and section shall be organized as a separate part of the Medical Staff and shall have a chief whose functions are described in Section 1.12.12. of the Bylaws and Section 3.1.6. of the Organizational Manual.

**1.12.11. Medical Executive Committee**

- A. Composition: shall consist of representatives of the active Medical Staff and administration. The Medical Executive Committee shall be a standing committee of the Medical Staff and shall consist of the following voting members:
  - 1. Medical Staff President
  - 2. Medical Staff Vice President
  - 3. Medical Staff Immediate Past President
  - 4. Chief Executive Officer
  - 5. Chief Medical Officer
  - 6. Physician-in-Chief
  - 7. Surgeon-in-Chief
  - 8. Administrative/Ambulatory Medical Director
  - 9. One (1) at-large representative appointed and able to be removed by the Medical Staff President (2 year term)
  - 10. Two (2) elected medical representatives at-large at least one of whom is a community practicing general pediatrician (2 year term); the next highest vote recipient will be the designated alternate as needed
  - 11. Two (2) elected surgical representatives at-large (2 year term); the next highest vote recipient will be the designated alternate as needed

- B. In case of an expected absence, it will be the responsibility of the elected representative to contact the appropriate designated alternate in a timely manner to represent him/her at the Medical Executive Committee meeting. The alternate shall have all the rights of the absent member. Anticipated absence of any members should be conveyed to the Medical Staff President.
- C. Should an at-large elected member of the Medical Executive Committee decide to step-down from the Medical Executive Committee, then the alternate will become a member of the Medical Executive Committee for the remainder of the (2) two year term, and the next highest vote recipient will become the new alternate.
- D. Any at-large representative may be removed from an elected position by two-thirds voting members present at any regular or special meeting of the General Staff. Written notification shall be submitted to the General Staff at least 10 days prior to the meeting. Removal may be based upon failure to perform the duties of the position held as described in these Medical Staff Bylaws or other reasons deemed sufficient by the Medical Executive Committee and/or the Medical Staff.
- E. The at-large members of the Medical Executive Committee shall be nominated and elected for a two year term in the same manner and at the same time as the nomination and election of the Medical Staff Officers.
- F. The individuals in positions set forth in Section 1.12.11.A.1. through 8. above shall be selected and removed from the Medical Executive Committee only as the person who holds each respective position changes in accordance with the Bylaws, Manuals, or Rules and Regulations or Hospital policies.
- G. To the extent eligible under these Bylaws, Medical Staff members of any discipline or specialty may serve on the Medical Executive Committee. At all times, physicians shall comprise at least a majority of the elected or appointed voting members of the Medical Executive Committee.
- H. Other Hospital leaders will be invited to the Medical Executive Committee for periodic reports as determined by the Officers of the Medical Staff in consultation with the Chief Medical Officer and Chief Executive Officer.
- I. Duties: The Medical Executive Committee shall:
  - 1. Represent and to act on behalf of the General Staff, subject to such limitations as may be imposed by these Bylaws and Manuals and by the Hospital's Code of Regulations;
  - 2. Coordinate the activities and general policies of the various Medical Staff departments and/or sections;

3. Receive and act on reports and recommendations from Medical Staff committees, departments and/or sections, and assigned activity groups of the Hospital. The Medical Executive Committee will delegate appropriate business to committees while retaining the right of executive responsibility and authority over all Medical Staff committees, except the Joint Conference Committee;
4. Implement policies of the Medical Staff not otherwise the responsibility of the departments and/or sections;
5. Serve as a liaison between the Medical Staff and the Chief Medical Officer, Chief Executive Officer and the Board of Directors;
6. Recommend action to the Chief Medical Officer and Chief Executive Officer on matters of a medical-administrative nature including the quality aspects of contracts for patient care services;
7. Fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to the patients in the Hospital. The Medical Executive Committee shall have access to the Board of Directors through the President of the Medical Staff, the Chief Medical Officer, the Chief Executive Officer, the Joint Conference Committee, and through its committee minutes;
8. Ensure that the Medical Staff is kept abreast of the Hospital's accreditation program and informed of the accreditation status of the Hospital;
9. Review and act on the recommendations of the Credentials Committee including:
  - a. Review the credentials of all applicants and making recommendations for Medical Staff appointment, assignments to departments and delineation of clinical privileges;
  - b. Periodically reviewing all information available regarding the performance and clinical competence of appointees and other persons with clinical privileges and, as a result of such reviews, making recommendations for reappointments and renewal or changes in clinical privileges;
  - c. Taking all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of all appointees, including the initiation of and/or participation in Medical Staff corrective action or review measures when warranted and implementation of any actions taken as a result thereof;

10. Report at General Staff meeting all actions affecting the General Staff;
11. Consider and make recommendations to the General Staff for the creation or deletion of sections when so recommended by the chief of the department concerned and/or the Chief Medical Officer;
12. Recommend the creation or deletion of departments of the Medical Staff subject to approval of these actions by the General Staff and the Board of Directors;
13. Recommend to the General Staff all changes in committee responsibilities, the creation of new standing committees, and the elimination of such committees as circumstances shall require. These recommendations shall become effective upon the approval of the Board of Directors;
14. Create and, through the President of the Medical Staff, appoint special committees when the need arises. The special committee shall receive a specific task to perform, shall be in existence for a specific period of time and shall have its task outlined in detail;
15. Make recommendations decisions regarding medical policy or Medical Staff policy changes or interdepartmental relationships, and may act as a mediator in all disputes arising between departments, sections, practitioners and/or Hospital or Medical Staff administration;
16. Inform the General Staff of significant actions taken which affect them during the period between General Staff meetings;
17. Review quality indicators to promote uniformity regarding patient care services;
18. Provide leadership in activities related to patient safety;
19. Provide oversight in the process of analyzing and improving patient satisfaction;
20. Make recommendations to the Board of Directors regarding Medical Staff structure; participation of the Medical Staff in performance improvement/quality assessment and utilization review activities; and mechanisms for Privileges delineation, credentials review, termination of Medical Staff appointment and/or Privileges, and fair hearing procedures;

21. Organize the Medical Staff's performance improvement/quality assessment, quality review and utilization management activities and establish a mechanism to conduct, evaluate and revise such activities after consultation with the appropriate department or section chief;
  22. Request evaluation of individuals privileged through the Medical Staff process in instances where there is doubt about the individual's ability to perform the Privileges requested; and
  23. Make recommendations to the Board regarding the Medical Executive Committee's review of and actions on reports of Medical Staff committees, departments and/or sections and other assigned activity groups.
- J. Meetings: the committee shall meet monthly and maintain minutes which shall be distributed to each committee member and to the Board of Directors.

**1.12.12. Qualifications and Roles and Responsibilities of Department and Section Chiefs**

- A. The department/section chief shall be board certified by an appropriate specialty board or shall affirmatively demonstrate established comparable competence through the Medical Staff credentialing process. The department/section chiefs shall have such other qualifications as are set forth in Section 3.1.5. of the Organizational Manual.
- B. In addition to the roles and responsibilities set forth in Section 3.1.6. of the Organizational Manual, each department and section chief shall be responsible for the following:
1. Clinically related activities of the department/section;
  2. Administratively related activities of the department/section, unless otherwise provided by the Hospital;
  3. Continuing surveillance of the professional performance of all individual in the department who have delineated clinical privileges;
  4. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department/section;
  5. Recommending clinical privileges for each member of the department/section;

6. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department/section or the organization;
7. Integration of the department/section or service into the primary functions of the organization;
8. Coordination and integration of interdepartmental and/or section and intradepartmental and/or section services;
9. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services in the department and/or section;
10. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services in the department and/or section;
11. Determination of the qualifications and competence of department/section or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
12. Continuous assessment and improvement, in conjunction with the Chief Medical Officer, of the quality of care, treatment, and services of the department and/or section;
13. Maintenance of quality control programs, as appropriate;
14. Orientation and continuing education of all persons in the department/section or service; and
15. Recommending space and other resources needed by the department/section or service.

## **1.13. Categories of the Medical and General Staff**

### **1.13.1. The Medical Staff**

The Medical Staff shall be comprised of all Hospital credentialed persons who are licensed to practice allopathic or osteopathic medicine and surgery, dentistry, podiatry or psychology. The Medical Staff shall consist of the following categories: Active, Administrative, Consulting, Retired, Emeritus, Affiliated, House Staff, Postgraduate Staff, and Associate Scientific Staff.

### **1.13.2. The Active Staff**

#### **A. Category I. Active with No Admitting/Management Privileges**

Shall consist of those credentialed practitioners who are not requesting clinical privileges but want to participate in various functions throughout the Hospital. Active staff members can:

1. Have view only access (no order writing) to electronic health care record of patients in their practice.
2. Teach and supervise house staff assigned by the section/department chief.
3. Be eligible to vote on any matters pertaining to Medical Staff business including the election of officers; representatives on the Medical Executive Committee; amendments to the Medical Staff Bylaws; changes to department and/or section rules and regulations
4. Contribute to the organizational administrative business matters of the Medical Staff and Hospital.
5. Be invited to attend educational programs of the Medical Staff and Hospital.
6. Receive all publications and communications of the Medical Staff and Hospital.
7. Be eligible to serve and vote on Medical Staff and Hospital committees.
8. Be eligible to hold medical staff leadership positions.
9. Attend Medical Staff and Hospital social functions.
10. Attend Medical Staff and section/department meetings.
11. Will pay annual Medical Staff dues.
12. Practitioners appointed to Category I are required to follow the reappointment procedure outlined in the Credentials Manual.

## B. Category II. Active with Admitting/Management Privileges

Shall consist of those credentialed practitioners who conduct a significant portion of their professional activity at Nationwide Children's Hospital, admit patients and exercise such clinical privileges as are granted specific to your specialty and who are able to provide continuous quality of care to their pediatric patients. Practitioners eligible to be appointed to this category are required to follow the reappointment procedure outlined in the Credentials Manual and meet **ONE** of the following criteria:

1. Exercising the responsibility for the admission and/or management of 10 or more Hospitalized patients in a two year period at Nationwide Children's Hospital or other institutions that will provide quality data reflective of the clinical privileges being requested at Nationwide Children's Hospital, **OR**
2. Participates in the management of inpatients and/or outpatients at Nationwide Children's Hospital, **OR**
3. Teaching and supervising medical/dental students and/or house staff of the Hospital either in inpatient areas, outpatient clinics/services or community-based offices and clinics.
4. Members of Category II can in addition to all the privileges of Active staff admit and/or manage patients consistent with their clinical privileges. Practitioners will have access to electronic health care records of patients in their practice.
5. Initial appointees to Category II will have admitting and/or management of patient activities monitored by a Focused Professional Practice Evaluation (FPPE) for a period of one year from the date of appointment, in accordance with the Professional Practice Evaluation Policy, Article 4.1. At the conclusion of the one year period, the department and/or section chief(s) is required to recommend to the Credentials Committee one of the following:
  - a. Continue appointment in Category II with Ongoing Professional Practice Evaluation (OPPE).
  - b. Extend the Focused Professional Practice Evaluation (FPPE) monitoring period until the appointee has successfully completed the number of procedures, patient encounters, and/or such other criteria as defined by and recommended by the appointee's department and/or section chief(s).
  - c. Appointment to Active – Category I.
  - d. Termination if the practitioner does not meet the criteria for appointment to another category.

6. Category II Active staff members can:
  - a. Teach and supervise house staff assigned by the section/department chief;
  - b. Be eligible to vote on any matters pertaining to Medical Staff business including the election of officers; representatives on the Medical Executive Committee; amendments to the Medical Staff Bylaws; changes to department and/or section rules and regulations;
  - c. Contribute to the organizational administrative business matters of the Medical Staff and Hospital;
  - d. Be invited to attend educational programs of the Medical Staff and Hospital;
  - e. Receive all publications and communications of the Medical Staff and Hospital;
  - f. Be eligible to serve and vote on Medical Staff and Hospital committees;
  - g. Be eligible to hold medical staff leadership positions;
  - h. Attend Medical Staff and Hospital social functions;
  - i. Attend Medical Staff and section/department meetings; and
  - j. Will pay annual Medical Staff dues.

### **1.13.3. Administrative Staff**

- A. The Administrative Staff category may be held by any practitioner with no clinical responsibilities and who is employed by the Hospital to perform ongoing administrative responsibilities. This may include department and section chiefs, medical administrative appointments, research administrators, the chief executive officer, the chief medical officer, and others as deemed appropriate by the Medical Staff Officers.
- B. Administrative Staff shall advise and assist the Chief Medical Officer or others as appropriate with the performance of administrative responsibilities.
- C. Administrative Staff shall not be eligible to admit patients or exercise clinical privileges.
- D. The information on the application will be verified with the primary sources. A completed application shall include but not be limited to the following information:

1. Professional education, training, and what portion of training was pediatric.
2. Current and prior affiliations with hospitals; surgery centers, ambulatory care centers; faculty and teaching appointments, etc.
3. Other affiliations with private practices, partnerships, corporations, military assignments, government agencies, etc.
4. Current and unrestricted Ohio license.
5. Out of state licenses.
6. Board status.
7. Affiliation with all local, state, and national professional societies.
8. Physical and mental health status.
9. Completion of immunization status questionnaire form.
10. Documented completion of annual PPD skin testing requirements (annual Mantoux PPD skin test) unless the practitioner has a history of a prior positive skin test. Those practitioners with a prior skin test will have to complete a questionnaire concerning symptoms related to tuberculosis. Failure by the practitioner to comply shall result in immediate suspension of medical staff privileges.
11. Peer references from three practitioners who are knowledgeable about the applicant's training, professional competence and/or character and who have known the application for at least one year (additional letters may be requested at the discretion of the department/section chief(s)).
12. Department/section assignment.
13. Evidence of continuing medical education activities as it relates to privileges granted.
14. Evidence of continuing medical education activities as it relates to privileges granted.
15. Previously successful or currently pending challenges to any licensure or registration (state or DEA) or the voluntary or involuntary relinquishment of such licensure or registration.
16. Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital.

17. Involvement in professional liability actions (pending claims, judgments or settlements); list all carriers used for the last ten years.
  18. A review of Medicare/Medicaid or other federal sanction(s).
  19. A review of incidents reportable to the National Practitioner Data Bank or other central agency; querying the National Practitioner Data Bank is required on all applicants applying for clinical privileges and membership.
  20. Documentation of professional liability insurance coverage in an amount not less than \$1 million per incident and \$1 million per annual aggregate. The amount required is determined by the Medical Executive Committee and approved by the Board of Directors.
  21. A recent photograph of the applicant.
  22. Results of criminal background check.
  23. The agreement to abide by the Hospital's policies and rules, the Hospital's corporate integrity plan and standards of conduct, and the Medical Staff Bylaws and Manuals.
- E.
1. Practitioners in the Administrative Staff category:
    - a. must have been board certified by the applicable national specialty board for their primary specialty/sub-specialty when such practitioners were engaged in the active practice of medicine; or
    - b. have been granted a waiver of the board certification requirement as set forth in Section 2.1D. of the Credentials Manual; or
    - c. must be eligible to be granted a waiver of the board certification requirements under Section 2.1D. of the Credentials Manual.
  2. Practitioners in the Administrative Staff category are encouraged but not required to maintain board certification.
  3. Practitioners assigned to the Administrative Staff category, are required to follow the initial and reappointment process outlined in the Credentials Manual except as otherwise provided herein.

F. Administrative Staff members can:

1. Teach and supervise house staff assigned by the section/department chief;
2. Be eligible to vote on any matters pertaining to Medical Staff business including the election of officers; representatives on the Medical Executive Committee; amendments to the Medical Staff Bylaws; changes to department and/or section rules and regulations;
3. Contribute to the organizational administrative business matters of the Medical Staff and Hospital;
4. Be invited to attend educational programs of the Medical Staff and Hospital;
5. Receive all publications and communications of the Medical Staff and Hospital;
6. Be eligible to serve and vote on Medical Staff and Hospital committees;
7. Be eligible to hold medical staff leadership positions; except as otherwise set forth in these Bylaws, Manuals and Regulations;
8. Attend Medical Staff and Hospital social functions;
9. Attend Medical Staff and section/department meetings; and
10. Will pay annual Medical Staff dues.

**1.13.4. The Consulting Medical Staff**

Shall consist of those credentialed practitioners who are of recognized professional ability and expertise to provide a service not readily available from the Active medical staff. Consulting staff members:

- A. Will not be eligible to admit patients.
- B. Will not be required to pay annual dues.
- C. Will not be eligible to vote on medical staff matters, medical staff committees, department/section meetings or hold office.

### **1.13.5. The Retired Medical Staff**

Shall consist of persons who have terminated their medical practice and participation in the Hospital Medical Staff for reasons of retirement. Retired staff members shall not be eligible to admit or treat patients, to vote or hold office of the Medical Staff, pay annual Medical Staff dues, nor shall they be expected to attend meetings or return reappointment forms. Retired staff members may serve on medical staff committees at the discretion of the President of the Medical Staff.

### **1.13.6. The Emeritus Medical Staff**

Recognition as Emeritus members will be reserved for past members of the Medical staff who have an outstanding record of contribution to Nationwide Children's Hospital. Emeritus staff members shall not be eligible to admit or treat patients, to vote or hold office of the Medical Staff, pay annual Medical Staff dues, nor shall they be expected to attend meetings or return reappointment forms. Emeritus staff members may serve on Medical Staff committees at the discretion of the President of the Medical Staff.

### **1.13.7. The Affiliated Medical Staff**

The Affiliated Medical Staff shall consist of Nationwide Children's Hospital credentialed persons who have primary involvement at another Hospital (Host Hospital) but who will provide care to pediatric patients in a Nationwide Children's Hospital operated unit located in the Host Hospital. Members of the Affiliated Medical Staff will:

- A. Maintain medical staff privileges at the Host Hospital.
- B. Be credentialed by Nationwide Children's Hospital to provide care to Nationwide Children's Hospital patients only at the Host Hospital.
- C. Be required to satisfy the qualifications for Nationwide Children's Hospital Medical Staff membership as stated in Article 3, Section 2.
- D. Be required to satisfy all applicable Nationwide Children's Hospital department/section rules and regulations.
- E. Be required to comply with all other applicable terms and conditions of the Nationwide Children's Hospital Medical Staff Manuals.
- F. Be required to maintain credentials at the Host Hospital.
- G. Be monitored by the Nationwide Children's Hospital Medical Staff via the site specific Chief Medical Officer.
- H. Pay annual Nationwide Children's Hospital Medical Staff dues.

- I. Serve on committees as appointed.
- J. Not be required to attend departmental and General Staff meetings.
- K. Not be eligible to hold office or vote except as a member of a committee.

#### **1.13.8. The General Staff**

The General Staff shall be comprised of the Medical/Surgical staff members and the following additional categories of licensed and Hospital-credentialed persons.

#### **1.13.9. The House Staff**

- A. Shall consist of practitioners or dentists who (1) have received an appointment at Nationwide Children's Hospital ("Hospital") in a Hospital approved graduate medical education ("GME") or dental education program; or (2) are enrolled in a GME approved program at another institution recognized by the Hospital and who are on their pediatric rotations at the Hospital (collectively referred to as "House Staff"). House Staff in an ACGME/AOA approved fellowship program will not be able to apply for appointment to the Medical Staff except as Postgraduate staff and as specifically set forth in section 1.13.10. House Staff in a non-ACGME/AOA approved fellowship program may apply for appointment to the Medical Staff as Active staff or Postgraduate staff. GME programs referred to in this section include education programs that are ACGME/AOA accredited, and also non-ACGME/ AOA accredited programs which have been approved by the Hospital.
- B. Application for appointment to House Staff will be made to the applicable program director with approval by the Chief of the applicable department and/or section.
- C. House Staff shall provide patient care only under the supervision of the practitioners who are credentialed and privileged by the Hospital to perform the services and who are designated by the program director as faculty who may supervise the House Staff in accordance with the GMEC policies. House Staff members are permitted to function clinically as outlined in this section 1.13.9. The House Staff shall perform their duties in accordance with written job responsibilities developed by the program directors according to the policy set forth by the Graduate Medical Education Committee (GMEC). Each GME program also describes the mechanisms through which program directors and attending faculty make decisions about a House Staff member's progressive involvement and independence in delivering patient care. House Staff may also provide clinical services outside of their respective GME program in accordance with the GME policy, and may do so only under the supervision requirements listed herein, unless the House Staff member has received an appointment as a member of the Hospital's Postgraduate staff (ACGME/AOA approved or non-ACGME/AOA approved program) or Hospital's Active staff (non-ACGME/AOA approved program) in accordance with 1.13.10.

- D. The ACGME Designated Institutional Official (DIO) communicates as needed, but at least annually, with the Medical Executive Committee (MEC) and the Hospital's Board of Directors about House Staff supervision, responsibilities, evaluation, compliance with duty-hour standard, and participation in patient safety and quality of care education. The DIO also coordinates with the MEC to ensure that all supervising practitioners possess clinical privileges commensurate with their supervising activities.
- E. Members of the House Staff may admit patients in accordance with their respective GME program and may only admit a patient to the service of their supervising attending physician.
- F. Members of the House Staff will not:
  - 1. Have admitting privileges to admit patients except as specifically set forth above.
  - 2. Be eligible to hold a Medical Staff office position.
  - 3. Vote in Medical Staff affairs, except as members of committees.
  - 4. Pay dues (unless they also have an appointment as Postgraduate staff or Active staff).
- G. House Staff are eligible to attend meetings, to serve on committees as designated by the Chief Medical Officer, and to function in the clinical areas of the Hospital within the limitations of their appointments.

#### **1.13.10. Postgraduate Staff**

- A. The Postgraduate Staff shall consist of House Staff who:
  - 1. Are Fellows or are advanced training residents.
  - 2. Have been granted approval to work outside of the fellowship program by the applicable program director and approved by the department and/or section chief(s). Without approval of program director and department and/or section chief(s), the individual is not eligible to apply for privileges and such denial shall not give rise to any hearing rights.
  - 3. Meet the basic requirements for credentialing and privileging set forth in the Credentials Manual.
  - 4. Are board certified or are qualified candidates for board certification at the time of initial appointment, and must meet the board certification requirements outlined in Credentials Manual.
  - 5. Are actively enrolled and have an appointment in a Hospital-sponsored GME program or a GME program recognized by the Hospital with a pediatric component at NCH. GME programs include ACGME or AOA accredited programs and non-ACGME accredited programs.

6. Seek, while enrolled in the GME program, to care for patients at the Hospital outside the scope and requirements of their GME program; under the auspices of an outpatient clinical department specifically approved by the applicable department and/or section chief(s) (“Assigned Clinical Department”); and under a contract with the Hospital.
7. Meet all of the Hospital’s GME requirements and policies and be in good standing in their training program.

B. The Postgraduate Staff Members can:

1. Engage in patient care activities in an outpatient care setting within the Assigned Clinical Department with appropriate clinical supervision.
2. Exercise only those clinical privileges as are granted to him/her pursuant to the delineation of privileges.
3. Attend meetings of the Medical Staff in the departments in which they are privileged.

C. Members of the Postgraduate Staff:

1. Shall not be eligible to admit patients or have Operating Room attending staff surgical privileges.
2. Shall not be eligible to hold office in the Medical Staff or to serve on standing Medical Staff committees. This does not preclude the possibility of serving on a Medical Staff committee as a designate of the department and/or section chief(s) of the department in which the Postgraduate Staff member is training.
3. Shall not be eligible to vote in any matters pertaining to Medical Staff business including the election of members and officers of the Medical Executive Committee; amendments to the Bylaws, Rules and Regulations, and Manuals; or other issues requiring a vote of the active staff.
4. Shall not perform clinical activities outside their respective training program or the Assigned Clinical Department.
5. Shall pay annual dues and application fees.

### **1.13.11. CME Participants for Direct Patient Care**

- A. Shall consist of practitioners or dentists who have been accepted into a Nationwide Children's Hospital ("Hospital") approved continuing medical education ("CME") or continuing dental education program (collectively "CME Participant Program for Direct Patient Care (CME-PC)").
- B. Application for acceptance into CME-PC Program will be made to the CME office.
- C. CME-PC participants shall provide patient care only under the supervision of the practitioners who are credentialed and privileged by the Hospital to perform the services and who are designated by the applicable CME program director as faculty who may supervise the CME-PC participants in accordance with the CME and NCH policies. CME-PC participants shall perform their duties in accordance with the written education program approved by the CME Committee. CME-PC participants may only provide clinical services outside of their respective CME program if they have also received an appointment as a member of the Hospital's Medical Staff and been granted privileges.
- D. Unless a CME-PC participant is also an active member of the Medical Staff, members of the CME-PC participant category will not:
  - 1. Have admitting privileges.
  - 2. Be eligible to hold a Medical Staff office position.
  - 3. Vote in Medical Staff affairs, except as members of committees.
  - 4. Pay dues (unless they also have an appointment as Postgraduate Staff).
- E. Unless a CME-PC participant is also an active member of the Medical Staff, CME-PC participants are only eligible to attend meetings, to serve on committees as designated by the Chief Medical Officer, and to function in the clinical areas of the Hospital within the limitations of their CME program.

### **1.13.12. The Associate Scientific Staff**

Shall consist of persons who assist the practitioners with the provision of patient care in the Hospital setting. Members of the Associate Scientific Staff are not so licensed to be members of the Medical Staff but have obtained a degree of Doctor of Philosophy, Science, or Pharmacy. The Associate Scientific Staff shall:

- A. apply as a member of the Associate Scientific Staff by recommendation of their respective medical staff department chief or Chief Medical Officer and will require the approval of the Credentials Committee and Medical Executive Committee of the Medical Staff.
- B. be employees of or under contract to the Hospital and responsible to an appropriate Medical Staff department chief and administrator.

- C. perform services in accordance with provisions relating to their respective profession contained in the job description approved by the Credentials Committee.
- D. comply with all limitations and restrictions imposed by the respective licenses, certification, or legal credentials referred to by Ohio Law.
- E. have no authority to admit patients to the Hospital.
- F. not be eligible to hold Medical Staff leadership position or to vote at Medical Staff meetings.
- G. be eligible to attend Medical Staff meetings and functions and serve as voting members on Medical Staff committees following approval of the Officers of the Medical Staff.
- H. pay annual Medical Staff dues as designated for the Medical Staff.
- I. not be afforded any hearing rights as outlined in Article 1. of these Bylaws but shall be afforded those rights of grievance outlined in the Hospital's Personnel Policy Guidelines.

#### **1.13.13. Allied Health Professionals (AHP)**

##### **A. Definition**

Allied Health Professionals are those individuals who possess a license, certificate or other legal credential required by Ohio law to provide direct patient care, but who are not practitioners or house staff. Examples of specified professional personnel are advance practice nurses (APN) and practitioner assistants (PA), etc.

##### **B. General**

1. All APN's and PA's must be employees of Nationwide Children's Hospital or an employee leased by Nationwide Children's Hospital (such as APN/PA working for the PAA or leased by Nationwide Children's Hospital for off-site NICU's) and must be appropriately credentialed according to Nationwide Children's Hospital policies and procedures. APN/PA's that are not employed/leased by Nationwide Children's Hospital will not be allowed to practice independently at Nationwide Children's Hospital.
2. Allied Health Professionals have no authority to admit or co-admit patients to the Hospital, and are not eligible for Medical Staff membership, to hold office, to vote at Medical Staff meetings, or to serve on Medical Staff committees unless specifically named by the President of the Medical Staff.

3. The Allied Health Professionals category is created for the purpose of providing a mechanism for the Medical Staff and the Hospital to document and verify the credentials of persons who, under their licensure, certificate or other legal credential are permitted by Ohio law to provide patient care in the Hospital as an adjunct to treatment by practitioners who are members of the Medical Staff.
4. All Allied Health Professionals will be individually assigned to Medical Staff departments, or if appropriate, to members of the Medical Staff, by the Human Resources Department.
5. All Allied Health Professionals employed by the Hospital will be responsible to an appropriate department head, (and/or administrator, if no department head exists) and will be under the supervision of a member of the Medical Staff.
6. Employees of a grant received by the Nationwide Children's Hospital are to be considered employed by the Hospital, and as such, fall under the same review/approval requirements as Hospital employees.
7. All Allied Health Professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials required by Ohio Law, and may perform services in accordance with provisions relating to their respective professions contained in the job descriptions and standard care arrangements if applicable, approved by the Credentials Committee, the Medical Executive Committee and the Board of Directors.
8. No Allied Health Professionals shall be afforded the hearing rights as outlined in the Medical Staff Bylaws, but shall be subject to the specified professional personnel hearing and appeal mechanism set forth under the policy for all Allied Health Professionals in the appropriate Medical Staff Manuals/Policies. Only Hospital employed Allied Health Professionals (including individuals hired on grants) shall be afforded those rights of employee grievance outlined in the Hospital's Human Resource policies.

C. Review Process

1. According to their scope and authority, the Credentials Committee shall review and approve job descriptions and standard care arrangements of all Allied Health Professionals positions (Hospital employed, practitioner employed, and other). Any revisions to job descriptions and standard care arrangements require review and approval of the Credentials Committee, Medical Executive Committee and the Board of Directors. The job descriptions shall specify:

2. The training, qualifications and credentials required for the job;
3. The duties and privileges of the job;
4. Medical staff and department head/administrative lines of supervision
5. For Hospital employed Allied Health Professionals, the selection and employment of personnel to fill the jobs shall be done by the appropriate Hospital/Medical Staff personnel. The performance of all Hospital employed Allied Health Professionals shall be reviewed by the appropriate Hospital personnel, as designated in the Hospital's personnel/administrative policies.
7. The practitioner employer of Allied Health Professionals shall be responsible for all actions of his/her privately employed specified professional personnel. The only Allied Health Professionals that may be employed by a practitioner rather than the Hospital are nurse anesthetists, scrub nurses, Operating Room practitioner extenders (technicians), and audiologists.

D. The Allied Health Professional Preceptor Program Staff (AHPP)

1. Shall consist of APN's who (1) meet the definition of Allied Health Professionals under Section 2.13.11 of the Credentials Manual; (2) who are directly employed by and have privileges at another Hospital; (3) are enrolled in a GME approved Preceptor Program at the Hospital (collectively referred to as AHPP Staff). Application for appointment to AHPP Staff will be made to the applicable Program Director with approval by the AHP Credentials Committee and the Chief of the applicable department/section.
2. AHPP Staff shall provide patient care only under the supervision of the physicians or other AHP's who are credentialed and/or privileged by the Hospital to perform the services and who are designated by the Program Director as faculty who may supervise the AHPP Staff in accordance with the AHP Credentials Committee policy and Graduate Medical Education Committee (GMEC) policies. AHPP Staff shall perform their duties in accordance with written job responsibilities developed by the Program Director according to the policy set forth by the AHP Credentials Committee and (GMEC). Each GME program also describes the mechanisms through which Program Directors and attending faculty make decisions about an AHPP Staff member's progressive involvement and independence in delivering patient care. AHPP Staff may not provide clinical services outside of the respective GME program.

#### **1.14. Medical History and Physical Examination Requirements**

- A. A medical history and physical examination shall be completed, documented, and authenticated for each patient no more than thirty (30) days before or twenty-four (24) hours after an inpatient admission or registration. A history and physical shall be completed, documented and authenticated by an attending physician prior to any surgery or procedure requiring anesthesia services. When the history and physical is completed within thirty (30) days before an admission or registration, an updated examination of the patient, including any changes in the patient's condition, shall be completed, documented, and authenticated by the attending physician within twenty-four (24) hours after an inpatient admission or registration, but prior to any outpatient or inpatient surgery or a procedure requiring anesthesia services.
- B. The history and physical, and any updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a practitioner, an oral maxillofacial surgeon, or other qualified licensed individual who has been granted privileges at the Hospital to do so and as permitted by state law and Hospital policy. APNs, PAs, and residents are permitted by the Hospital to complete and document history and physicals and any updates thereto.
- C. The history and physical, and any updates thereto, must be completed using the history and physical note type in the electronic medical record, if available, or otherwise in the proper medical record (and, if performed by an individual who is not an attending physician, validated and authenticated by an attending physician), dated, timed and made a part of the patient's medical record within twenty-four (24) hours after admission of the patient.
- D. Additional requirements regarding completion and documentation of the medical history and physical examination are set forth in Section 5.2.D. of the Rules and Regulations.

### **1.15. Meeting Attendance Requirements**

All Medical Staff members are encouraged to attend their specific department/section meetings and General Staff meetings for any calendar year. Any vote of the Medical Staff required to be taken at a meeting of the Medical Staff or General Staff may, in the alternative, be taken through electronic communications as follows. The Executive Assistant to the Medical Staff will post information about the issue to be voted on at the Medical Staff Services site on the Nationwide Children's Hospital webpage (currently <http://www.nationwidechildrens.org/medical-staff-office>), as such site may be amended from time to time. The Executive Assistant to the Medical Staff will then send an electronic communication such as email to all of the voting members of the Medical Staff notifying them that the issue has been posted and providing them with ten (10) business days to vote on the issue by responding to the electronic communication. The outcome of the vote will be determined by the required majority needed to pass the vote as set forth in the applicable section of the Bylaws based on the number of voting members that submit a vote in response to the electronic communication, provided however, that at least thirty (30) voting members must respond.

## **1.16. ADOPTION/AMENDMENTS**

- A. The Medical Staff has the ability to adopt or amend the Bylaws, Manuals, and Rules and Regulations. The Medical Staff hereby delegates to the Bylaws Committee, with the approval of the Medical Executive Committee, the responsibility to adopt and amend such provisions of the Manuals and Rules and Regulations as may be necessary to implement the general principles set forth in these Bylaws and for the proper conduct of the Medical Staff. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Bylaws, the Manuals, or the Rules and Regulations.
- B. The Bylaws Committee shall review the Bylaws, Rules/Regulations, and Manuals of the Medical Staff to assure compliance with any applicable state and federal laws or regulations and the continuing needs of the Medical Staff. Such review will be conducted on an annual basis or at the call of the chairperson of the Bylaws Committee.
- C. A proposal to amend these Bylaws, Rules/Regulations and Manuals may be offered by any member of the Active Medical Staff at any meeting of the General Staff or to a member of the Medical Executive Committee. The proposal will then be referred to the Medical Executive Committee, through the Bylaws Committee, for examination. Nothing in the foregoing is intended to prevent a member of the Medical Staff from proposing amendments to the Bylaws, Manuals, or Rules and Regulations to the Board of Directors in writing or in a manner that is otherwise determined by the Board.
- D. For any proposed amendment to Article 1: Bylaws Manual, the Bylaws Committee will report its recommendation regarding the proposed Bylaws amendment to the Credentials Committee, if the proposed amendment relates to an issue that is governed by the Credentials Committee. The Bylaws Committee and, if applicable, the Credentials Committee will report their recommendations to the Medical Executive Committee. Bylaws amendment recommendations approved by the Medical Executive Committee will be presented to the Medical Staff by the Medical Executive Committee at any meeting of the General Staff meeting. At least 15 days advance notice of such meeting will be sent to all Medical Staff members and the notice will include the wording of the Bylaws amendment proposal to be considered. To be adopted, a Bylaws amendment shall require a 2/3 majority vote of those voting members present at the meeting. Amendments so accepted by the Medical Staff will be presented to the Board of Directors, and if approved, will become effective as of the date adopted by the Board of Directors.
- D. For any proposed amendment to Article 2: Credentials Manual, Article 3: Organizational Manual, or Article 4: Practitioner Effectiveness Manual, the Bylaws Committee will report its recommendation regarding such proposed amendment to the Credentials Committee, if the proposed amendment relates to an issue that is governed by the Credentials Committee. The Bylaws Committee and, if applicable, the Credentials Committee will report their recommendations to the Medical Executive Committee.

Amendment recommendations under this Section 1.14(d) approved by 80% of the Medical Executive Committee members voting and present at a meeting in which a quorum exists will be communicated to the Medical Staff and will be presented to the Board of Directors. If approved by the Board of Directors, the amendment will become effective as of the date adopted by the Board of Directors. If any proposed amendment under this Section 1.14(d) does not receive 80% of the Medical Executive Committee vote as set forth above, then the proposed amendment will be presented to the Medical Staff by the Medical Executive Committee at any meeting of the General Staff. At least 15 days advance notice of such meeting will be sent to all Medical Staff members, and the notice will include the wording of the Manuals amendment proposal to be considered. To be adopted, a Manuals amendment shall require a 2/3 majority vote of those voting members present at the meeting. Amendments so accepted by the Medical Staff will be presented to the Board of Directors, and if approved, will become effective as of the date adopted by the Board of Directors.

- E. For any proposed amendment to Article 5: Rules and Regulations, the Bylaws Committee will communicate such proposed amendment to the Medical Staff and then report its recommendation regarding such proposed amendment to the Medical Executive Committee. Amendment recommendations under this Section 1.14(e) approved by 80% of the Medical Executive Committee members voting and present at a meeting in which a quorum exists will be presented to the Board of Directors, and if approved, will become effective as of the date adopted by the Board of Directors. If any proposed amendment under this Section 1.14(e) does not receive 80% of the Medical Executive Committee vote as set forth above, then the proposed amendment will be presented to the Medical Staff by the Medical Executive Committee at any meeting of the General Staff. At least 15 days advance notice of such meeting will be sent to all Medical Staff members, and the notice will include the wording of the Rules and Regulations amendment proposal to be considered. To be adopted, a Rules and Regulations amendment shall require a 2/3 majority vote of those voting members present at the meeting. Amendments so accepted by the Medical Staff will be presented to the Board of Directors, and if approved, will become effective as of the date adopted by the Board of Directors.
- F. The Executive Assistant to the Medical Staff, in consultation with the Senior Vice President for Legal Services, shall have the authority to make modifications relating to cross-references, renumbering, punctuation, spelling, or other errors of grammar or expression.

- G. In the event of a documented need for an urgent amendment to a Rule or Regulation necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the Board may provisionally approve such urgent amendment without prior notice to the Medical Staff. In such event, the Medical Staff shall thereafter be immediately notified by the Medical Executive Committee and shall be provided with the opportunity for retrospective review of, and comment on, the provisional amendment. If the Medical Staff does not object to the Medical Executive Committee's action, the provisional amendment shall stand. Any such objection and the reasons for the objection shall be raised in writing with a member of the Medical Executive Committee within ten (10) days of the notice being sent. If such an objection is submitted to the Medical Executive Committee, the provisional amendment and the objection will be referred to Bylaws Committee, and a revised amendment will be proposed in accordance with the provisions of Section 1.16.F. If necessary to resolve a dispute related to an urgent amendment, the process for conflict resolution set forth in Section 1.17 may be implemented.

### **1.17. Medical Staff / Medical Executive Committee Conflict Resolution**

In the event of a conflict between the Medical Staff and the Medical Executive Committee, that does not otherwise have a process for resolution under the Bylaws, Manuals, or Rules and Regulations, a special meeting of the Medical Staff and the Medical Executive Committee shall be convened as set forth in Section 3.3.6 of the Organizational Manual to discuss issues of concern and resolution thereof. In the event that the issue cannot be resolved to the mutual satisfaction of both parties, the matter shall be brought before the Medical Staff for vote, that shall require a 2/3 majority vote to present a proposed resolution to the Board of Directors. If passed, such resolution shall be presented to the Board of Directors and shall be subject to final review, approval, and action by the Board of Directors.