NATIONWIDE CHILDREN'S HOSPITAL TOLEDO MEDICAL STAFF BYLAWS

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PREAMBLE

Whereas, Nationwide Children's Hospital Toledo is a limited liability company organized under the laws of the State of Ohio; and,

Whereas, the Hospital's 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 Managers, and that the cooperative efforts of the Medical Staff, the Chief Medical Officer, the Chief Operating Officer, and Board of Managers 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 Bylaws and Policies.

DELEGATION OF AUTHORITY

Since final accountability for the quality of care rendered at the Hospital rests with the Board of Managers, they, as the governing body, grant to qualified and eligible Practitioners and Advanced Practice Providers Medical Staff appointment and/or Privileges, as applicable, upon the recommendation of the Medical Staff through its duly authorized officers, committees, and Members.

The Medical Staff is responsible to the Board of Managers to see that Practitioners and Advanced Practice Providers granted, as applicable, Medical Staff appointment and/or Privileges at the Hospital provide care, treatment, and/or services within the scope of the Privileges granted to them.

The Board of Managers has delegated authority to the Medical Staff to be self-governing in accordance with the requirements set forth in the Medical Staff Bylaws and Policies and to form its committees freely so that the Medical Staff as a professional body might review the competence of Practitioners and Advanced Practice Providers requesting and/or granted Privileges at the Hospital and make recommendations to the Board of Managers for official action. The intent of this delegation of authority is to promote the continual advancement of health care.

Subject to the authority and approval of the Board of Managers, the Medical Staff shall exercise such power as is reasonably necessary to discharge its responsibilities under the Medical Staff Bylaws and Policies, and under the Hospital's governing documents.

DEFINITIONS

Advanced Practice Provider or APP means those physician assistants, advanced practice registered nurses, and other eligible APPs, as designated in the APP Policy, who have applied for and/or been granted Privileges to practice at the Hospital either independently (as applicable) or in collaboration with or under the supervision of a Medical Staff appointed Physician, Dentist, or Podiatrist with Privileges at the Hospital.

Adverse means a recommendation or action of the Medical Executive Committee or Board that (1) denies or terminates Medical Staff appointment; and/or (2) denies, limits (*i.e.*, suspension, restriction, *etc.*) for a period in excess of fourteen (14) days, or terminates the Privileges of a Medical Staff Member on the basis of professional conduct or clinical competence, or as otherwise defined in these Medical Staff Bylaws or the Fair Hearing Policy.

Affiliate Hospital(s) means Nationwide Children's Hospital.

Board of Managers or **Board** means the governing body of the Hospital. A reference to the "Board of Managers" or "Board" shall include the Board's designee(s).

Chief Medical Officer or **CMO** means the individual appointed by the Hospital to be responsible for the clinical work, medical education, and quality of patient care delivered throughout the Hospital and its related companies.

Chief Operating Officer or **COO** means the individual appointed by the Board to act on its behalf in the overall operation and management of the Hospital.

Clinical Privileges or **Privileges** means the permission granted by the Board to a Practitioner or Advanced Practice Provider to render designated patient care, treatment, and/or clinical services, pursuant to an applicable Delineation of Privileges, at/for the Hospital based upon the individual's professional license, education, training, experience, competence, ability, character, and judgment.

Dentist means an individual who has received a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.") degree and who is currently licensed to practice dentistry in Ohio; and whose practice is in the area of oral and maxillofacial surgery, general dentistry, or a specialty thereof.

Ex Officio means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided in the Bylaws or Policies, means without voting rights. Persons serving in an *Ex-Officio* capacity shall not be counted in determining the existence of a quorum unless otherwise provided in the Bylaws or Policies.

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

Good Standing means the Practitioner, during the time at issue, meets all applicable requirements for his or her Medical Staff appointment category and Department and is not currently experiencing a suspension or curtailment of appointment and/or Privileges at the Hospital other than an automatic suspension for delinquent medical records.

Hospital means Nationwide Children's Hospital Toledo including all its clinical departments, programs, services, and provider-based locations.

Medical Executive Committee or **MEC** means the executive committee of the Hospital's Medical Staff.

Medical Staff means those Practitioners who have been granted appointment to the Hospital's Medical Staff with such rights and responsibilities as defined in the Medical Staff category to which each has been appointed.

Medical Staff Bylaws or Bylaws means the articles herein and amendments thereto that constitute the basic governing document of the Medical Staff.

Medical Staff Department or Department means those clinical services designated as Medical Staff Departments as provided for in the Medical Staff Organization Policy. Departments may be further divided into Sections led by Section Chiefs.

Medical Staff Department Chair or Department Chair means a Member of the active Medical Staff category with Privileges in the Department who reports to the Medical Staff President and the CMO.

Medical Staff Member or Member means a Practitioner who has been granted appointment to the Hospital's Medical Staff. A Medical Staff Member must also have applied for and been granted Privileges unless the appointment is to a Medical Staff category without Privileges, or unless otherwise provided in the Bylaws. References to Medical Staff appointee or appointment shall mean the same thing as Medical Staff Member or membership for purposes of the Medical Staff Bylaws and Policies.

Medical Staff Policy or **Policies** means those Medical Staff policies, recommended by the Medical Executive Committee and approved by the Board, that serve to implement the Medical Staff Bylaws including the Credentials Policy, Organization Policy, Fair Hearing Policy, Advanced Practice Provider Policy, Practitioner/Advanced Practice Provider Effectiveness Policy, and the Clinical Care Policy.

Medical Staff President means a Member of the active Medical Staff category with Privileges at the Hospital who is elected to serve as the administrative leader of the Medical Staff.

Medical Staff Section Chief or **Section Chief** means a Member of the active Medical Staff category with Privileges in the Section who reports to the Department Chair and the CMO.

Medical Staff Year means the twelve (12) month period commencing on January 1 of each year and ending on December 31.

Patient Encounter means a professional contact between a Practitioner and a patient, whether an admission, consultation, or diagnostic, operative, or invasive procedure at the Hospital.

Physician means an individual who holds a Doctor of Medicine ("M.D.") or Doctor of Osteopathic Medicine ("D.O.") degree and who is currently licensed to practice medicine in Ohio.

Podiatrist means an individual who holds the degree of Doctor of Podiatric Medicine (D.P.M.) and who is currently licensed to practice podiatry in Ohio.

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

Professional Liability Insurance means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as recommended by the MEC and approved by the Board.

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

Special Notice means written notice sent by (a) certified mail, return receipt requested; or (b) by personal delivery service with signed acknowledgment of receipt.

ARTICLE 1 NAME, PRINCIPLES AND RESPONSIBILITIES OF THE MEDICAL STAFF

1.1. Name

1.1.1. The name of the Medical Staff shall be the Nationwide Children's Hospital Toledo Medical Staff.

1.2. Principles of the Medical Staff

1.2.1. The Hospital has an organized, self-governing Medical Staff that:

a. Ensures that all patients admitted to or treated at the Hospital receive care without regard to their race, religion, age, sex, gender identity or expression, sexual orientation, culture, language, ethnicity/national origin, physical or mental disability, or socioeconomic status/ability to pay.

b. Is accountable to the Board for: the quality and appropriateness of the medical/other professional care, treatment, and services provided to patients by Practitioners and APPs granted Privileges at the Hospital; the clinical competence and professional/ethical conduct of its Practitioners and APPs; and, for confirming that appropriate criteria are in place to evaluate the quality of care rendered by Practitioners and APPs granted Privileges at the Hospital.

c. Provides oversight for uniform quality of care, treatment, and services at the Hospital by recommending qualified Practitioners and APPs for Clinical Privileges and qualified Practitioners for appointment to the Medical Staff.

d. Creates a framework of self-governance, enforcement, compliance, and accountability to the Board through the development and implementation of Medical Staff Bylaws and Policies.

e. Provides a mechanism for creation, adoption, and amendment of applicable Delineations of Clinical Privileges and for monitoring and evaluating the clinical performance of Practitioners and APPs with delineated Clinical Privileges through Medical Staff participation in quality, performance improvement, and peer review processes.

f. Provides a means for the Medical Staff to communicate effectively with the Board and Hospital administration and to represent itself and participate in all Hospital deliberations affecting the discharge of the Medical Staff's responsibilities.

g. Supports research and educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.

1.3. Responsibilities of the Medical Staff

1.3.1. The responsibilities of the Medical Staff are to:

a. Conduct the following activities and oversee the quality and efficiency of patient care provided by all Practitioners and APPs granted Privileges to practice in the Hospital:

1. Review and evaluation of the quality of patient care through valid and reliable methods.

2. Ongoing monitoring of selected patient care practices through defined mechanisms and Medical Staff organizational components.

3. Credentials evaluation and the mechanisms for Medical Staff appointment, reappointment, and clinical privileging.

4. Continuing education programs fashioned, at least in part, on needs demonstrated through the established patient care evaluation mechanisms.

5. Utilization review to allocate inpatient medical and health services based upon patient specific determinations of individual medical needs.

b. Recommend to the Board action with respect to Medical Staff appointments, reappointments, Medical Staff category and Department/Section assignments, Clinical Privileges, and corrective action.

c. Recommend to the Board programs for the establishment, maintenance, continuing improvement, and enforcement of professional standards in the delivery of health care within the Hospital.

d. Account to the Board for the quality and efficiency of patient care though regular reports and recommendations as appropriate.

e. Initiate and pursue corrective action with respect to Practitioners and APPs, when warranted.

f. Develop, administer, recommend amendments to, and enforce these Bylaws and other Medical Staff and Hospital policies.

g. Assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

h. Exercise the authority granted by these Medical Staff Bylaws as necessary to adequately fulfill the foregoing responsibilities.

1.4. Use of an Authorized Designee

1.4.1. Whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g.*, the Chief Operating Officer, CMO, Medical Staff President, Department Chair, *etc.*), then reference to the individual shall also include the individual's authorized designee.

1.5. Not a Contract

1.5.1. The Medical Staff Bylaws and Policies are not intended to and shall not create any contractual rights between the Hospital and any individual Practitioner or APP or any group of Practitioners or APPs. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and its Practitioners and APPs.

ARTICLE 2 MEDICAL STAFF APPOINTMENT AND PRIVILEGING

2.1. Nature of Appointment and/or Privileges

2.1.1. Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner may be granted Medical Staff appointment with Privileges, Medical Staff appointment without Privileges, or Privileges without a Medical Staff appointment.

2.1.2. Medical Staff appointment and Privileges shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Policies.

2.1.3. No Practitioner, including those employed by or contracted with the Hospital, shall admit or provide care, treatment, and/or services to patients in the Hospital unless the Practitioner has been granted Clinical Privileges to do so in accordance with the applicable procedures set forth in these Medical Staff Bylaws and/or the Credentials Policy.

2.1.4. A Practitioner who is granted appointment to the Medical Staff is entitled to such rights and is responsible for fulfilling such obligations as set forth in the Medical Staff Bylaws and Policies and category to which the Practitioner is appointed. Appointment to the Medical Staff shall confer on the Medical Staff Member only such Clinical Privileges as have been granted in accordance with the applicable procedures set forth in these Medical Staff Bylaws and/or the Credentials Policy.

2.1.5. A Practitioner who is granted Clinical Privileges is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in the Medical Staff Bylaws and Policies and the applicable Delineation of Privileges (*i.e.,* Privilege set).

2.2. Qualifications for Appointment and/or Privileges

2.2.1. Unless otherwise provided in the Medical Staff Bylaws or Policies, in order for a Practitioner to be eligible for Medical Staff appointment and/or Privileges at the Hospital a Practitioner must meet the following qualifications:

a. Have and maintain a current, valid license/certificate issued by the State of Ohio to independently practice his/her respective profession and meet the continuing education requirements established by the applicable State licensure board.

b. Have and maintain a current, valid Drug Enforcement Administration registration number if required for the Privileges requested.

c. Provide documentation of completion of professional education as required by the applicable State licensing entity and such additional education as may be set forth in the applicable Delineation of Privileges.

d. Provide, if applicable, documentation of successful completion of an ACGME and/or AOA approved residency in the specialty/specialties in which the applicant seeks Privileges. Applicants shall also provide documentation of successful completion of other postgraduate training programs, internships, and/or fellowships, as applicable, with specification as to pediatric training.

e. Provide documentation of board certification and maintenance of certification in his/her area(s) of practice at the Hospital by the appropriate specialty/subspecialty board(s) in accordance with the requirements set forth in the Credentials Policy.

f. Have and maintain current, valid Professional Liability Insurance in an amount no less than one million dollars ($1,000,000,000) per incident and three million dollars ($3,000,000,000) annual aggregate.

g. Be able to participate in Federal Health Programs.

h. Have and maintain a provider number for Medicare issued by the United States Department of Health & Human Services and a provider number for Medicaid issued by the Ohio Department of Medicaid and be a Medicare and Medicaid participating provider.

i. Have not been convicted of or pled guilty to any of the violations described in division (A)(4) of section 109.572 of the Ohio Revised Code (O.R.C) which disqualify the applicant from employment or appointment at a children's hospital pursuant to section 2151.86 of the O.R.C. In the event an applicant seeks to request a waiver of this qualification on the grounds that the applicant meets the rehabilitation standards as provided for in O.R.C. 109.572(A)(4), the applicant shall follow the waiver procedure set forth in Section 2.2-2 below.

j. Satisfy such other qualifications as set forth in the applicable Medical Staff category and Privilege set.

k. Provide such other information as set forth in the Credentials Policy and as required by the Medical Staff application.

l. Provide evidence of the Practitioner's ability to work with others in a positive, professional, cooperative, and collegial manner.

m. Document and demonstrate current ability to competently perform the Privileges requested or granted with or without a reasonable accommodation

n. Document prior and current experience demonstrating a continuing ability to provide patient care, treatment, and/or services at an acceptable level of quality and efficiency and consistent with available resources and applicable standards of care.

o. Document and demonstrate adherence to the applicable code of professional ethics and good character/judgment.

p. Comply with the Board and/or Hospital conflict of interest policies, if any, as applicable.

q. Agree to fulfill, and fulfill, the responsibilities, as applicable, set forth in the Medical Staff governing documents.

2.2.2. Waiver of Qualifications for Medical Staff Appointment and/or Privileges

a. A written request for a waiver of a qualification for Medical Staff appointment and/or Privileges may be submitted by the Practitioner for consideration by the MEC and Board. Qualifications for Medical Staff appointment and/or Privileges may be waived, at the sole discretion of the Board, based upon exceptional circumstances and a Board determination that such waiver will serve the best interests of patient care. The MEC will make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Upon receipt of the MEC's recommendation, the Board shall either grant or deny the waiver request. Once a waiver is granted, it shall remain in effect from the time it is granted until the Practitioner's resignation or termination of Medical Staff appointment/Privileges unless a shorter time period is recommended by the MEC and approved by the Board. The Practitioner must thereafter reapply for the waiver.

b. No Practitioner is entitled to a waiver. A determination by the Board not to grant a Practitioner's request for a waiver; or, the Hospital's inability to process an application; or, termination of a Practitioner's appointment and/or Privileges based upon failure to satisfy the qualifications for Medical Staff appointment and/or Privileges does not give rise to any procedural rights nor does it create a reportable event for purposes of federal or state law.

2.3. Basic Responsibilities of Practitioners Granted Medical Staff Appointment and/or Privileges

2.3.1. Unless otherwise provided in the Medical Staff Bylaws or Policies, each Practitioner granted Medical Staff appointment and/or Privileges at the Hospital shall, as applicable to the Medical Staff appointment and/or Privileges granted to each such Practitioner:

a. Provide patients with quality of care meeting the professional standards of the Hospital's Medical Staff.

b. Abide by the Medical Staff Bylaws and Policies, Hospital policies (including, but not limited to, the Hospital's corporate compliance program, conflict of interest policies, if applicable, and Notice of Privacy Practices distributed to patients as required by federal patient privacy regulations), and applicable accreditation standards, laws, rules, and regulations.

c. Discharge such Medical Staff, committee, Department, Section, and Hospital functions for which he/she is responsible by Medical Staff category, assignment, appointment, election, or otherwise.

d. Prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or in any way provides care, treatment, or services for in the Hospital.

e. Successfully complete required education/training on use of the Hospital's electronic health record prior to exercise of Privileges at the Hospital; and, thereafter, timely complete such other technology related education/training as may be directed by the MEC.

f. Appropriately utilize the Hospital's electronic health record system for order entry and for all other appropriate functionalities.

g. Participate in providing care, treatment, and services consistent with the Hospital's mission.

h. Assist with Medical Staff approved clinical education training programs for students, interns, and residents.

i. Provide continuous care and supervision of his/her patients or otherwise arrange a suitable alternate to provide such care and supervision.

j. Call for consultation and/or assistance, as needed, in the care of patients; and, provide consultation and assistance in his/her respective area of expertise and for which he/she has Clinical Privileges when requested.

k. Satisfy any continuing medical/other professional education requirements necessary to maintain his/her licensure or that may otherwise be established by the Medical Staff.

l. Participate in such emergency service coverage and consultation panels as may be required by the Medical Staff to the extent applicable to the Medical Staff category to which the Practitioner is appointed.

m. Comply with such notification requirements as set forth in these Medical Staff Bylaws and Policies.

n. Work in a cooperative, professional manner and refrain from any conduct or activity that is disruptive to Hospital operations.

o. Participate in, and cooperate with, peer review, quality assurance, and utilization review activities, whether related to the Practitioner or others, as requested by the Medical Staff.

p. Cooperate in any relevant or required review of the Practitioner's or others' credentials, qualifications, clinical performance, or as otherwise required by the Medical Staff Bylaws or Policies and refrain from directly or indirectly interfering, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to perform or participate in assigned responsibilities, or otherwise.

q. Conduct himself/herself consistent with Hospital and Medical Staff policies regarding conflicts of interest and otherwise act in such a manner that potential conflicts of interest are specifically stated prior to discussions and/or voting on issues where such a conflict may exist.

r. Adhere to applicable professional ethical practice guidelines.

s. Participate in and complete the applicable Department orientation for new Practitioners.

t. Comply with Hospital health screening and immunization requirements (or be granted an exemption thereto) as set forth in the applicable Hospital policies and/or Medical Staff Policies.

u. Timely complete required Hospital education and training (*e.g.*, fire safety, *etc.*).

v. Discharge such other Medical Staff obligations as may be recommended by the Medical Executive Committee and approved by the Board.

2.3.2. Failure to satisfy any of the aforementioned responsibilities may be grounds for denial of Medical Staff reappointment and/or regrant of Privileges or corrective action pursuant to these Bylaws.

2.4. Overview of Credentialing, Appointment, and Privileging Process

2.4.1. Unless otherwise provided in these Medical Staff Bylaws or the applicable Medical Staff Policy:

a. Applications for appointment/reappointment and/or grant/regrant of Privileges shall be submitted to the Medical Staff Office who shall review each application for completeness and perform primary source verification.

b. When collection and verification is accomplished, the application and accompanying materials shall be reviewed and acted upon by the applicable Department Chair, the Chief Medical Officer, and the Medical Executive Committee.

c. Initial appointments and reappointments to the Medical Staff and granting/regranting of Privileges shall be made by the Board. The Board shall act on appointments/reappointments and Privileges/regrant of Privileges only after there has been a recommendation from the MEC; provided, however, that the Board may act directly (in accordance with the procedure set forth in the Credentials Policy or APP Policy, as applicable) if the Board does not receive a recommendation from the MEC. Prior to taking such action, the Board will inform the MEC of the Board's intent and allow a reasonable period of time for response from the MEC.

2.4.2. The details related to the mechanisms for credentialing/recredentialing, processing applications for initial appointment, for reappointment, and for granting/regranting Privileges to Practitioners are set forth in the Medical Staff Credentials Policy.

2.4.3. The details related to the mechanisms for credentialing/recredentialing and processing applications for granting/regranting Privileges to Advanced Practice Providers are set forth in the Advanced Practice Providers Policy.

2.4.4. The Chief Operating Officer, Chief Medical Officer, or Medical Staff President may grant disaster Privileges to licensed volunteer Practitioners and Advanced Practice Providers for the purpose of providing care, treatment, and services to patients in the event that the Hospital's emergency management plan is activated and the Hospital is unable to meet immediate patient needs. Granting of disaster Privileges shall be in accordance with the applicable procedure set forth in the Medical Staff Credentials Policy (for Practitioners) and Advanced Practice Provider Policy (for Advanced Practice Providers).

2.4.5. Granting of temporary Privileges shall be in accordance with the applicable procedure set forth in the Medical Staff Credentials Policy (for Practitioners) and APP Policy (for APPs).

2.4.6. Granting of telemedicine Privileges to distant-site telemedicine Practitioners who will not practice on-site at the Hospital shall be in accordance with the applicable procedure set forth in the Medical Staff Credentials Policy.

2.5. Assessments and Dues

2.5.1. The Medical Executive Committee shall have the authority to determine the amount of Medical Staff assessments and annual dues.

2.5.2. Initial applicants will be assessed a non-refundable processing fee upon submitting an application for Medical Staff appointment and/or Clinical Privileges at the Hospital. Failure to pay such fee will be deemed a voluntary withdrawal of the application.

ARTICLE 3 MEDICAL STAFF CATEGORIES

3.1. Category I: Active Medical Staff Category without Privileges

3.1.1. The active Medical Staff category without Privileges shall consist of those credentialed Practitioners who are not requesting Privileges at the Hospital but want to participate in various Medical Staff functions throughout the Hospital for which Privileges are not needed. Practitioners appointed to the active Medical Staff category without Privileges shall satisfy the qualifications set forth in Section 2.2 unless otherwise recommended by the Medical Executive Committee and approved by the Board.

3.1.2. Active Medical Staff Members without Privileges shall:

a. Pay annual Medical Staff dues.

b. Fulfill the responsibilities set forth in Section 2.3 to the extent such responsibilities are applicable to a Practitioner granted Medical Staff appointment without Privileges.

3.1.3. Active Medical Staff Members without Privileges may:

a. Not be granted Clinical Privileges.

b. Have view only access (no order writing, *etc.*) to the electronic health care records of patients in their practice.

c. Vote on any matters pertaining to Medical Staff business including, but not limited to, the election of Medical Staff officers; at-large representatives on the Medical Executive Committee; and amendments to the Medical Staff Bylaws.

d. Contribute to the organizational, administrative, and/or business matters of the Medical Staff and Hospital.

e. Attend educational programs of the Medical Staff and Hospital.

f. Receive publications and communications of the Medical Staff and Hospital.

g. Serve as a committee member or chair, subject to satisfaction of the applicable qualifications, and vote on matters of Medical Staff committees of which he/she is a member.

h. Not serve as a Medical Staff officer or as a Department Chair or Section Chief.

i. Attend Medical Staff and Hospital social functions.

j. Attend Medical Staff meetings and those Department/Section and committee meetings of which he/she is a member.

k. Vote on matters of the Department/Section of which the Practitioner is a member.

3.2. Category II: Active Medical Staff Category with Privileges

3.2.1. The active Medical Staff category with Privileges shall consist of those credentialed Practitioners who conduct a significant portion of their professional activity at the Hospital, admit patients, and exercise such Clinical Privileges as are granted specific to their specialty and who are able to provide continuous quality care to their pediatric patients. Practitioners appointed to the active Medical Staff category with Privileges shall satisfy the qualifications set forth in Section 2.2, unless otherwise recommended by the Medical Executive Committee and approved by the Board, and shall meet **ONE** of the following criteria:

a. Have ten (10) or more Patient Encounters at the Hospital during each appointment/Privilege period. If a Practitioner fails to meet the Patient Encounter requirements following completion of two (2) consecutive appointment/Privilege periods, the Practitioner will be transferred to another Medical Staff category for which he/she is eligible, if any, in the absence of a showing, satisfactory to the MEC and Board, that this was due to unusual circumstances unlikely to occur in the next appointment/Privilege period; **OR**

b. Teach and supervise medical/dental/podiatric students, residents, and/or fellows at the Hospital and/or Hospital provider-based locations.

3.2.2. Active Medical Staff Members with Privileges shall:

a. Pay annual Medical Staff dues.

b. Be expected to attend Medical Staff meetings and those Department/Section and committee meetings of which he/she is a member unless otherwise excused.

c. Attend patients, regardless of their ability to pay, as required; consult, consistent with his/her scope of practice and the Privileges granted, with other Practitioners and APPs; and serve on the on-call roster for the purpose of assignment to patients who do not have an attending Practitioner.

e. Fulfill the responsibilities set forth in Section 2.3.

3.2.3. Active Medical Staff Members with Privileges may:

a. Exercise the Clinical Privileges granted.

b. Teach and supervise medical/dental/podiatric students, residents, and/or fellows at the Hospital and/or Hospital provider-based locations as assigned by the Department Chair or Section Chief, as applicable.

c. Vote on any matters pertaining to Medical Staff business including, but not limited to, the election of Medical Staff officers; at-large representatives on the Medical Executive Committee; and amendments to the Medical Staff Bylaws.

d. Attend educational programs of the Medical Staff and Hospital.

e. Receive publications and communications of the Medical Staff and Hospital.

f. Serve, subject to satisfaction of the applicable qualifications, as a committee member or chair and vote on matters of Medical Staff committees of which he/she is a member.

g. Contribute to the organizational, administrative, and/or business matters of the Medical Staff and Hospital.

h. Serve as a Medical Staff officer or Department Chair or Section Chief subject to satisfaction of the applicable qualifications.

i. Attend Medical Staff and Hospital social functions.

j. Vote on matters of the Department/Section of which he/she is a member.

3.3. Administrative Medical Staff Category

3.3.1. The administrative Medical Staff category may be held by any Practitioner with no clinical responsibilities (*i.e.*, who is not requesting Privileges) and who is employed or contracted by the Hospital to perform ongoing administrative responsibilities. This may include medical administrative appointments, research administrators, and others as deemed appropriate by the MEC.

a. Practitioners appointed to the administrative Medical Staff category, without Privileges, are not required to have a Medicare/Medicaid number.

b. Practitioners appointed to the administrative Medical Staff category, without Privileges, must have attained initial board certification from the applicable national specialty board set forth in Section 7.1-1 of the Medical Staff Credentials Policy and are encouraged, but not required, to maintain board certification.

c. With the exception of Section 3.3.1 (a) and (b), Practitioners appointed to the administrative Medical Staff category, without Privileges, shall satisfy the qualifications set forth in Section 2.2 unless otherwise recommended by the Medical Executive Committee and approved by the Board.

3.3.2. Administrative Medical Staff Members shall:

a. Advise and assist the Chief Medical Officer or others as appropriate with the performance of administrative responsibilities.

b. Pay annual Medical Staff dues.

c. Fulfill the responsibilities set forth in Section 2.3 to the extent such responsibilities are applicable to a Practitioner granted Medical Staff appointment without Privileges.

3.3.3. Administrative Medical Staff Members may:

a. Not be granted Clinical Privileges.

b. Vote on any matters pertaining to Medical Staff business including, but not limited to, the election of Medical Staff officers; the election of at-large representatives to the Medical Executive Committee; and amendments to the Medical Staff Bylaws.

c. Contribute to organizational, administrative, and/or business matters of the Medical Staff and Hospital.

d. Attend educational programs of the Medical Staff and Hospital.

e. Receive publications and communications of the Medical Staff and Hospital.

f. Serve as a committee member or chair, subject to satisfaction of the applicable qualifications, and vote on Medical Staff committees of which he/she is a member; provided, however, that an administrative Medical Staff Member may not serve as an MEC at-large representative.

g. Not serve as a Medical Staff officer.

h. Attend Medical Staff and Hospital social functions.

i. Attend Medical Staff meetings and those Department/Section and committee meetings of which he/she is a member.

j. Vote on matters of the Department/Section of which the Practitioner is a member.

k. Not serve as a Department Chair or Section Chief.

3.4. <u>Consulting Medical Staff Category</u>

3.4.1. The consulting Medical Staff category shall consist of those credentialed Practitioners who:

a. Are of recognized professional ability and expertise and able to provide a service not readily available from the active Medical Staff Members with Privileges; and

b. Satisfy the qualifications set forth in Section 2.2 unless otherwise recommended by the Medical Executive Committee and approved by the Board; and

c. Are members in good standing of the active medical staff category with clinical privileges at another accredited Ohio hospital requiring performance improvement/quality assessment activities similar to those of the Hospital. The Practitioner shall hold at such other hospital the same privileges, without restriction, that he/she is requesting at Hospital. An exception to this qualification may be recommended by the Medical Executive Committee and made by the Board, in its sole discretion, for good cause provided the Practitioner is otherwise qualified by education, training, and experience to competently provide the requested care, treatment, and/or services.

3.4.2. The consulting Medical Staff Members shall:

a. Not be required to pay annual Medical Staff dues.

b. Fulfill the responsibilities set forth in Section 2.3.

3.4.3. Consulting Medical Staff Members may:

a. Exercise the Clinical Privileges granted.

b. Attend Medical Staff meetings but will not be eligible to vote on Medical Staff matters; nor chair, serve, or vote on Medical Staff committees.

c. Attend meetings of the Department/Section of which he/she is a member but may not vote on Department/Section matters.

d. Not hold Medical Staff office or serve as a Department Chair or Section Chief.

e. Attend educational programs of the Medical Staff and Hospital.

f. Receive publications and communications of the Medical Staff and Hospital.

g. Attend Medical Staff and Hospital social functions.

3.5. Retired Medical Staff Category

3.5.1. The retired Medical Staff category shall consist of current Medical Staff Members who have retired from medical practice. Members appointed to the retired Medical Staff category shall not be required to maintain a license to practice or to satisfy such other qualifications in Section 2.2 as are required of Practitioners who are granted Privileges. Current eligible Medical Staff Members may request transfer to the retired Medical Staff category in accordance with the procedure set forth in Section 3.3 of the Medical Staff Credentials Policy.

3.5.2. Retired Medical Staff Members shall:

a. Not be required to pay annual Medical Staff dues.

b. Have no Medical Staff duties pursuant to Section 2.3.

3.5.3. Retired Medical Staff Members may:

a. Not be granted Clinical Privileges.

b. Not hold Medical Staff office or serve as a Department Chair or Section Chief.

c. Attend Medical Staff meetings but may not vote on Medical Staff matters.

d. Not be assigned to a Department/Section or vote on Department/Section matters.

e. Chair or serve on Medical Staff committees at the discretion of the President of the Medical Staff and may vote on matters for those committees to which the Practitioner is appointed.

f. Attend educational programs of the Medical Staff and Hospital.

g. Receive publications and communications of the Medical Staff and Hospital.

h. Attend Medical Staff and Hospital social functions.

3.6. Honorary/Emeritus Medical Staff Category

3.6.1. Appointment to the honorary/emeritus Medical Staff category will be reserved for past Members of the active Medical Staff category who provided significant service in support of the Hospital's mission and values while a Member of the active Medical Staff category; or who have an outstanding record of contribution to the Hospital, an exceptional and distinctive pediatric reputation, and demonstrated commitment to the Hospital's mission and values.

a. Practitioners appointed to the honorary/emeritus Medical Staff category shall not be required to maintain a license to practice or to satisfy such other qualifications in Section 2.2 as are required of Practitioners who are granted Privileges.

b. Past Members of the active Medical Staff category may be nominated for the honorary/emeritus Medical Staff category by any current Medical Staff Member. Appointment and reappointment to the honorary/emeritus Medical Staff category requires a recommendation of the MEC and approval by the Board.

3.6.2. Honorary/emeritus Medical Staff Members shall:

a. Not be required to pay annual Medical Staff dues.

b. Have no Medical Staff duties pursuant to Section 2.3.

3.6.3. Honorary/emeritus Medical Staff Members may:

a. Not be granted Clinical Privileges.

b. Attend Medical Staff meetings but may not vote on Medical Staff matters or hold Medical Staff office.

c. Not be assigned to a Department/Section, serve as a Department Chair/Section Chief, or vote on Department/Section matters.

d. Chair or serve on Medical Staff committees, subject to satisfaction of the applicable qualifications, at the discretion of the President of the Medical Staff and may vote on matters for those committees to which the Practitioner is appointed.

e. Attend educational programs of the Medical Staff and Hospital.

f. Receive publications and communications of the Medical Staff and Hospital.

g. Attend Medical Staff and Hospital social functions.

ARTICLE 4 MEDICAL STAFF OFFICERS

4.1. Designation of Medical Staff Officers

4.1.1. The officers of the Medical Staff shall be the:

a. Medical Staff President

b. Vice-President

c. Immediate Past President

4.2. Qualifications of Medical Staff Officers

4.2.1. Qualifications of Medical Staff Officers. Each Medical Staff officer shall:

a. Be a Member of the active Medical Staff category with Clinical Privileges in Good Standing at the time of nomination and election/succession and must remain so throughout his/her term of office.

b. Have been recognized for a high level of clinical competence in his/her field and have demonstrated executive and administrative ability through active participation in Medical Staff activities and other relevant experience.

c. Have demonstrated a high level of interest in and support of the Medical Staff and Hospital.

d. Willingly and faithfully exercise the duties and authority of the office held and work collegially with the other Medical Staff officers, Department Chairs, Hospital administration, and the Board.

e. Not have a disqualifying conflict of interest as determined by the Board (or Chief Operating Officer and CMO as the Board's authorized designees).

4.3. Nominating Committee

4.3.1. Unless otherwise provided in the Medical Staff Organization Policy, the Chief Medical Officer shall be a member of the Nominating Committee and remaining members of the Nominating Committee shall be appointed by the Chief Medical Officer and the Medical Staff President.

4.3.2. At the appropriate time, the Nominating Committee shall meet and submit to the Medical Staff the nomination of at least two (2) (if possible) eligible Medical Staff Members for the following Medical Staff office:

a. Vice-President

4.4. Election of Vice-President

4.4.1. Only Medical Staff Members appointed to the active or administrative Medical Staff category are eligible to vote.

4.4.2. Election for the Vice-President is conducted, without a Medical Staff meeting, by written (*i.e.*, paper or electronic) ballot. Ballots shall be distributed, in such manner as determined appropriate by the MEC, to each Medical Staff Member eligible to vote. Completed ballots must be returned within the time period specified and according to the instructions that accompany the ballot.

4.4.3. The nominee for the office of Vice-President who receives a majority of the valid votes cast by the specified deadline shall be elected. Ballots received after the stipulated date shall not be counted.

4.4.4. If no candidate for the office of Vice-President receives at least 51% of the valid votes cast by the specified deadline (or in the event of a tie) a runoff election will be held between the two candidates receiving the highest number of votes (or tie vote).

4.4.5. Results of the election will be announced at the next Medical Staff meeting following the close of the voting period or as otherwise determined by the MEC.

4.5. Automatic Succession

4.5.1. The Vice-President shall automatically succeed to the office of Medical Staff President upon completion of his/her term as Vice-President.

4.5.2. The Medical Staff President shall automatically succeed to the office of Immediate Past President upon completion of his/her term as Medical Staff President.

4.6. Term

4.6.1. Each Medical Staff officer shall serve a term of two (2) years. Each Medical Staff officer shall serve until the end of this/her term, and until a successor is selected, unless he/she sooner resigns or is removed from the office.

4.7. Vacancy

4.7.1. In office of Medical Staff President. In the event of a vacancy in the office of the Medical Staff President, the Vice-President will serve the balance of the vacating Medical Staff President's term followed by the Vice-President's own term as Medical Staff President.

4.7.2. In office of Vice-President. In the event of a vacancy in the office of the Vice-President, a special election shall be conducted as soon as reasonably possible, in accordance with the procedure set forth in Section 4.3 and Section 4.4, to fill the vacancy for the remainder of the current term. Thereafter, the Medical Executive Committee shall determine whether the new Vice-President will serve an additional term as Vice-President or automatically succeed to the office of Medical Staff President.

4.7.3. In the office of Immediate Past President. In the event of a vacancy in the office of the Immediate Past President, the MEC may either elect to leave the office vacant or to appoint an interim Immediate Past President to fill the vacancy until the current Medical Staff President automatically succeeds to the office of Immediate Past President.

4.8. Resignation

4.8.1. A Medical Staff officer may resign at any time by giving written notice to the MEC.

4.8.2. Such resignation shall take effect on the date specified in the resignation notice or as otherwise agreed upon by the MEC and the resigning officer.

4.9. Removal

4.9.1. A Medical Staff officer may be removed as follows:

a. By the Board in consultation with the MEC. In the event that the MEC disagrees with the Board's decision to remove a Medical Staff officer, the matter will be referred to the Joint Conference Committee for its review and recommendation prior to final action by the Board.

OR

b. Any Medical Staff Member eligible to vote may present to the MEC a request to consider the removal of a Medical Staff officer accompanied by a petition signed by at least 25% of the Medical Staff Members eligible to vote. Upon receipt of such petition, removal of such Medical Staff officer shall require:

1. An affirmative two-thirds (2/3) vote of the members of the MEC eligible to vote who are present at a MEC meeting (called for the purpose of acting upon the requested removal) at which a quorum is present.

OR

2. An affirmative majority vote of those Medical Staff Members eligible to vote who are present at a Medical Staff meeting (called for the purpose of acting upon the requested removal) at which a quorum is present.

c. Written notification of the meeting at which a removal vote will be taken, and the basis for the action, shall be given to all individuals entitled to attend the meeting, including the Practitioner subject to removal, at least ten (10) days prior to the meeting. The Practitioner subject to removal shall be given an opportunity to speak on his/her own behalf at the meeting prior to such vote.

4.9.2. Permissible grounds for removal of a Medical Staff officer include, but are not limited to:

a. Failure to continuously satisfy the qualifications for the office set forth in Section 4.2.1 (b)-(d).

b. Failure to perform the duties of the office held in a timely and appropriate manner.

c. Inability to fulfill the duties of the office.

d. Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or corrective action undertaken against the Practitioner which results in a final Adverse decision.

e. Conduct or statements detrimental to the interests of the Medical Staff or Hospital or to their goals, programs, or public image.

4.9.3. Failure to remain a Member of the active Medical Staff category with Privileges in Good Standing during the term of his/her office shall immediately create a vacancy in the office involved.

4.9.4. Automatic termination of Medical Staff appointment and/or Privileges shall result in automatic removal of a Practitioner from his/her Medical Staff office.

4.9.5. Automatic removal of a Practitioner from his/her Medical Staff office may also occur as a result of a disqualifying conflict of interest pursuant to Section 4.2.1 (e) and any applicable conflict of interest policy.

4.10. Duties of Medical Staff Officers

4.10.1. The Medical Staff President shall:

a. Coordinate and cooperate with the Chief Operating Officer and CMO in all matters of mutual concern within the Hospital.

b. Aid in coordinating the activities and concerns of Hospital administration, nursing, and other patient care services with those of the Medical Staff.

c. Call, preside at, and oversee preparation of the agenda for all meetings of the Medical Staff.

d. Serve as a voting member and chair of the MEC and as a voting or non-voting member of such other Medical Staff committees as set forth in the Medical Staff Organization Policy.

e. Enforce the Medical Staff Bylaws and Policies and applicable Hospital policies and procedures; implement sanctions where indicated; and oversee the Medical Staff's compliance with appropriate procedures as set forth in these Bylaws in all instances where corrective action has been requested against a Practitioner.

f. Report the views, needs, policies, and concerns of the Medical Staff to the Board, the Chief Operating Officer, and the CMO.

g. Communicate Hospital policies to the Medical Staff and report to the Board regarding the Medical Staff's delegated responsibility for the performance and maintenance of quality medical care.

h. Be responsible for the educational activities of the Medical Staff.

i. Direct the development, implementation, and day-to-day functioning and organization of the Medical Staff components of the quality, peer review, and utilization management programs; assure that such programs are clinically and professionally sound, accomplish established objectives, and are compliant with regulatory and accrediting agency requirements; and report to the Board regarding such programs and activities.

j. Perform such other duties and exercise such authority commensurate with the office as set forth in the Medical Staff Bylaws and Policies or as otherwise may be reasonably requested, from time to time, by the MEC, the Board, the Chief Operating Officer, or the CMO.

4.10.2. The Vice-President shall:

a. Serve as a voting member of the MEC and as a voting or non-voting member of such other Medical Staff committees as set forth in the Medical Staff Organization Policy.

b. Assume the duties of the Medical Staff President in the event that the Medical Staff President is unable to fulfill his/her obligations.

c. Perform such additional duties as may be reasonably requested by the Medical Staff President, the MEC, or the Board.

4.10.3. The Immediate Past President shall:

a. Serve as a voting member of the MEC and as a voting or non-voting member of such other Medical Staff committees as set forth in the Medical Staff Organization Policy.

b. Perform such additional duties as may be reasonably requested by the Medical Staff President or the MEC.

4.11. Requirements Regarding Meetings of the Medical Staff

4.11.1. Requirements with respect to meetings of the Medical Staff (including, but not limited to notice, quorum, manner of action, *etc.*) shall be set forth in the Medical Staff Organization Policy.

ARTICLE 5 MEDICAL STAFF DEPARTMENTS & SECTIONS

5.1. Medical Staff Departments

5.1.1. Medical Staff Departments may be created, renamed, eliminated, or combined (*e.g.,* for better organizational efficiency and improved patient care) upon recommendation of the MEC and approval by the Board.

5.1.2. The current Medical Staff Departments are set forth in the Medical Staff Organization Policy.

5.2. Medical Staff Sections

5.2.1. The MEC shall determine, subject to the approval of the Board and after consulting with the appropriate Department Chair, what, if any, specialty Sections will exist within each Medical Staff Department.

5.2.2. The current Medical Staff Sections are set forth in the Medical Staff Organization Policy.

5.3. Qualifications of Medical Staff Department Chairs and Section Chiefs

5.3.1. Each Department Chair and Section Chief shall be a Member of the active Medical Staff category with Privileges in the applicable Medical Staff Department or Section; remain in Good Standing throughout his/her term; and be willing and able to faithfully discharge the functions of his/her position.

5.3.2. Department Chairs and Section Chiefs shall be well qualified by training, experience, and demonstrated ability for the position. It is imperative that these Practitioners be pediatric specialists with their primary activities, interests, and concerns being in the area of teaching, patient care, and research at the Hospital unless otherwise approved by the Medical Executive Committee and the Board.

5.3.3. Department Chairs and Section Chiefs shall be certified by an appropriate specialty board or demonstrate comparable competence affirmatively established through the Medical Staff credentialing process.

5.3.4. Not have a disqualifying conflict of interest as determined by the Board (or Chief Operating Officer and CMO as the Board's authorized designees).

5.4. Duties of Medical Staff Department Chairs & Section Chiefs

5.4.1. In addition to the roles and responsibilities set forth in the Organization Policy, each Department Chair/Section Chief shall be responsible for the following:

a. Overseeing the clinically related activities of the Department/Section.

b. Overseeing the administratively related activities of the Department/Section unless otherwise provided by the Hospital.

c. Continuing surveillance of the professional performance of all Practitioners and APPs in the Department/Section who have delineated Clinical Privileges.

d. Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department/Section.

e. Recommending Clinical Privileges for each member of the Department/Section.

f. 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.

g. Integration of the Department/Section into the primary functions of the organization.

h. Coordination and integration of interdepartmental and intradepartmental services.

i. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

j. Recommending a sufficient number of qualified and competent persons to provide care, treatment, and services.

k. Determining the qualifications and competence of Department/Section personnel who provide patient care, treatment, and services but are not licensed to practice independently.

l. Continuous assessment and improvement of the quality of care, treatment, and services.

m. Maintenance of quality control programs, as appropriate.

n. Orientation and continuing education of all persons in the Department/Section.

o. Recommending space and other resources needed by the Department/Section.

p. Such other duties as may be set forth in the Medical Staff Organization Policy.

5.5. Additional Information Regarding Department Chairs and Section Chiefs

5.5.1. Additional details regarding Medical Staff Department Chairs & Section Chiefs including, but not limited to, the procedure for selecting and removal of Department Chairs and Section Chiefs is set forth in the Medical Staff Organization Policy.

ARTICLE 6 MEDICAL EXECUTIVE COMMITTEE

6.1. MEC Composition

6.1.1. Composition: The Medical Executive Committee shall consist of representatives of the active and administrative Medical Staff categories and administration. To the extent eligible under these Bylaws, active and administrative Medical Staff Members of any discipline or specialty may serve on the Medical Executive Committee. At all times, Physician Members of the active Medical Staff category with Privileges shall comprise at least a majority of the elected and appointed voting members of the Medical Executive Committee.

a. 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 (MEC chair)

2. Medical Staff Vice President

3. Medical Staff Immediate Past President

4. Department Chair of Pediatrics

5. Chief Medical Officer

6. Chief Operating Officer

7. One (1) MEC at-large representative (who satisfies the qualifications set forth in Section 6.1.2 (a) appointed for a two-year term and able to be removed by the Medical Staff President

8. Two (2) MEC medical at-large representatives (who satisfy the qualifications set forth in Section 6.1.2 (a) elected for a two-year term pursuant to Section 6.1.2 (b) and able to be removed pursuant to Section 6.1.2 (f). The next highest vote recipient will be the designated alternate as needed.

9. One (1) MEC surgical at-large representative (who satisfies the qualifications set forth in Section 6.1.2 (a) elected for a two-year term pursuant to Section 6.1.2 (b) and able to be removed pursuant to Section 6.1.2 (f). The next highest vote recipient will be the designated alternate as needed.

b. The Chief Nursing Officer, elected at-large representative alternates, and such other guests as the MEC deems appropriate may attend MEC meetings; provided, however, that such individuals shall not have the right to vote on MEC matters unless he/she is otherwise serving as the designee of a voting MEC member.

c. In case of an expected absence, it will be the responsibility of the elected at-large 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 absences of MEC members should be conveyed to the Medical Staff Office.

d. Guests may be invited by the Medical Staff President to attend designated meetings of the Medical Executive Committee to provide periodic reports as determined by the officers of the Medical Staff in consultation with the Chief Medical Officer and the Chief Operating Officer.

6.1.2. MEC At-Large Representatives

a. Qualifications. Each appointed and elected MEC at-large representative shall:

1. Be a Member of the active Medical Staff category, with or without Clinical Privileges, in Good Standing.

2. Be willing and able to faithfully discharge the duties of his/her position.

3. Not have a disqualifying conflict of interest as determined by the Board (or Chief Operating Officer and CMO as the Board's authorized designees).

b. Nomination and Election Process for Elected MEC At-Large Representatives.

1. The Nominating Committee shall submit to the Medical Staff the nomination of at least two (2) (if possible) nominees for each available elected MEC at-large member position.

2. Only Medical Staff Members appointed to the active or administrative Medical Staff category are eligible to vote, with one vote for each elected MEC at-large member position on the ballot.

3. Elections for the elected MEC-at-large member positions are conducted, without a Medical Staff meeting, by written (*i.e.*, paper or electronic) ballot. Ballots shall be distributed, in such manner as determined appropriate by the MEC, to each Medical Staff Member eligible to vote. Completed ballots must be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the deadline will not be counted.

4. The nominee for the MEC at-large member position who receives a majority of the valid votes cast by the specified deadline for such position shall be elected.

5. If no candidate for the MEC at-large member position receives at least 51% of the valid votes cast by the specified deadline (or in the event of a tie) a runoff election will be held between the two candidates for the position receiving the highest number of votes (or tie vote).

6. Results of the election will be announced at the next Medical Staff meeting following the close of the voting period or as otherwise determined by the MEC.

c. Term of Appointed & Elected MEC At-Large Representatives. Each appointed and elected MEC at-large member shall serve a term of two (2) years. Each appointed and elected MEC at-large member shall serve until the end of his/her term, and until a successor is selected, unless he/she sooner resigns or is removed from the position. A MEC at-large representative may not serve more than three consecutive two-year terms.

d. Resignation. An appointed or elected MEC at-large member may resign at any time by giving written notice to the MEC. Such resignation shall take effect on the date specified in the resignation notice or as otherwise agreed upon by the MEC and the resigning MEC at-large member.

e. Vacancy in Appointed & Elected MEC At-Large Representative Position.

1. A vacancy in the appointed MEC at-large representative position shall be filled in the same manner in which the original appointment was made.

2. 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 an at-large member of the Medical Executive Committee for the remainder of the two year term and the next highest vote recipient will become the new alternate.

f. Removal of Elected MEC At-Large Representative

1. Any elected at-large representative may be removed from the MEC by an affirmative vote of two-thirds (2/3rd) of the members of the Medical Executive Committee eligible to vote who are present at a MEC meeting (called for the purpose of acting upon the requested removal) at which a quorum is present.

2. Written notification of the meeting at which a removal vote will be taken, and the basis for the action, shall be given to all individuals entitled to attend the meeting, including the Practitioner subject to removal, at least ten (10) days prior to the meeting. The elected MEC at-large representative subject to removal will be afforded the opportunity to speak on his/her own behalf at the meeting before a vote is taken.

3. Permissible grounds for removal of an elected MEC at-large representative include, but are not limited to:

i. Failure to perform the duties of the position held in a timely and appropriate manner.

ii. Inability to fulfill the duties of the position.

iii. Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or corrective action undertaken against the elected MEC at-large representative that results in a final Adverse decision.

iv. Conduct or statements detrimental to the interests of the Medical Staff or Hospital or to their goals, programs, or public image.

4. Failure to remain a Member of the active Medical Staff category with Privileges in Good Standing during the term of his/her position shall immediately create a vacancy in the position involved.

5. Imposition of an automatic termination of Medical Staff appointment and Privileges shall result in an automatic removal of the MEC at-large representative from his/her position.

6. Automatic removal of a Practitioner from his/her MEC at-large representative position may also occur as a result of a disqualifying conflict of interest pursuant to Section 6.1.2 (a)(3) and any applicable conflict of interest policy.

6.1.3. Selection and Removal of MEC Members

a. The MEC members set forth in Section 6.1-1 (a)(1) through (a)(5) 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 or applicable Hospital/Medical Staff policies.

1. Selection and removal of Medical Staff officers is addressed in Article IV of these Bylaws.

2. Selection and removal of Department Chairs is addressed in Article V of these Bylaws and in the Medical Staff Organization Policy.

3. Selection and removal of the Chief Operating Officer and CMO is addressed by the Board.

b. Selection and removal of the appointed MEC at-large representative is addressed in Section 6.1.1.

c. Section and removal of elected MEC at-large representatives is addressed in Section 6.1.2.

6.2. MEC Duties

6.2.1. The Medical Executive Committee shall:

a. Represent and act on behalf of the Medical Staff between Medical Staff meetings subject to such limitations as may be imposed by these Bylaws, Medical Staff/Hospital policies, and by the Hospital's Operating Agreement.

b. Coordinate the activities of the various Medical Staff Departments and/or Sections.

c. Receive and act on reports and recommendations from Medical Staff committees, Departments and/or Sections, and assigned activity groups. The Medical Executive Committee will delegate appropriate business to committees while retaining the right of executive responsibility and authority over all Medical Staff committees.

d. Implement and enforce the Medical Staff Bylaws and policies of the Medical Staff, not otherwise the responsibility of the Departments and/or Sections, and applicable Hospital policies.

e. Serve as a liaison between the Medical Staff and the Chief Medical Officer, Chief Operating Officer, and the Board.

f. Recommend action to the Chief Medical Officer and Chief Operating Officer on matters of a medical-administrative nature including the quality aspects of contracts for patient care services.

g. Fulfill the Medical Staff's accountability to the Board for the medical care rendered to the patients in the Hospital. The Medical Executive Committee shall have access to the Board through the President of the Medical Staff, the Chief Medical Officer, the Chief Operating Officer, the Joint Conference Committee, and through its committee minutes.

h. Ensure that the Medical Staff is kept abreast of the Hospital's accreditation program and informed of the accreditation status of the Hospital.

i. Review the credentials of all applicants and make recommendations for Medical Staff appointment/reappointment, assignment to Departments/Sections, and delineation of Clinical Privileges.

j. Periodically review all information available regarding the performance and clinical competence of Members and other Practitioners/APPs with Clinical Privileges and, as a result of such reviews, make recommendations for, as applicable, reappointments and/or regrant or changes in Clinical Privileges.

k. Take all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of all Practitioners and Advanced Practice Providers 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.

l. Report at Medical Staff meeting all actions affecting the Medical Staff.

m. Make recommendations with respect to Medical Staff Departments, Sections, and Medical Staff committees.

n. Create and, through the President of the Medical Staff, appoint special Medical Staff committees when the need arises. The special Medical Staff committee shall

receive a specific task to perform, shall be in existence for a designated period of time, and shall have its duties outlined in detail.

o. Make recommendations regarding medical policy decisions, Medical Staff Policy changes, or interdepartmental relationships, and act as a mediator in disputes arising between Departments, Sections, Practitioners/APPs, and/or Hospital or Medical Staff administration.

p. Inform the Medical Staff of significant actions taken which affect them during the period between Medical Staff meetings.

q. Review quality indicators to promote uniformity regarding patient care services.

r. Provide leadership in activities related to patient safety.

s. Provide oversight in the process of analyzing and improving patient satisfaction.

t. Make recommendations to the Board 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.

u. 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 Chair or Section Chief.

v. Request evaluation of Practitioners and Advanced Practice Providers privileged through the Medical Staff process in instances where there is doubt about the Practitioner's or Advanced Practice Provider's ability to perform the Privileges granted.

w. Make recommendations to the Board regarding the Medical Executive Committee's review of and actions on reports of Medical Staff committees, Departments, Sections, and other assigned activity groups.

x. Adopt and amend Medical Staff Policies in accordance with the applicable procedure set forth in Article XI of these Bylaws.

y. Make recommendations to the Medical Staff for adoption and amendment of the Medical Staff Bylaws in accordance with the applicable procedure set forth in Article XI.

z. Perform such other duties as requested by the Medical Staff or as set forth in the Medical Staff governing documents and/or applicable accreditation standards.

6.2.2. Meetings: The MEC shall meet monthly, as needed, and otherwise at the call of the MEC chair and shall maintain minutes which shall be distributed to the Board.

6.3. Other Standing Medical Staff Committees

6.3.1. The composition, duties, and meeting requirements regarding other standing Medical Staff committees are set forth in the Medical Staff Organization Policy.

ARTICLE 7 COLLEGIAL INTERVENTION/INFORMAL REMEDIATION, FORMAL CORRECTIVE ACTION, SUMMARY SUSPENSION & AUTOMATIC SUSPENSION/AUTOMATIC TERMINATION

7.1. Collegial Intervention & Informal Remediation

7.1.1. Prior to initiating formal corrective action against a Medical Staff Member for professional conduct or clinical competency concerns, the Medical Staff leadership or Board (through the Chief Operating Officer or CMO as its administrative agent) may elect to attempt to resolve the concerns informally in a manner that it determines appropriate.

7.1.2. An appropriately designated Medical Staff peer review committee may enter into a voluntary remedial agreement with a Medical Staff Member to resolve potential clinical competency or conduct issues.

7.1.3. If the affected Medical Staff Member fails to abide by the terms of an agreed-to remedial agreement, the Member may be subject to the formal corrective action procedure set forth in Section 7.2.

7.1.4. Nothing in this Section shall be construed as obligating the Hospital or Medical Staff leadership to engage in collegial intervention or informal remediation prior to implementing formal corrective action on the basis of a single incident.

7.1.5. A written record of any collegial intervention and/or informal remediation efforts will be prepared and maintained in the Medical Staff Member's confidential peer review file.

7.2. Formal Corrective Action

7.2.1. Grounds for Formal Corrective Action

a. Corrective action may be taken whenever a Medical Staff Member engages in activities or exhibits actions, statements, demeanor, or conduct within or outside of the Hospital that is/are, or is/are reasonably likely to be:

1. Contrary to the Medical Staff Bylaws or applicable Hospital or Medical Staff policies or procedures.

2. Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.

3. Disruptive to Hospital operations.

4. Damaging to the Medical Staff's or the Hospital's reputation.

5. Below the applicable standard of care.

6. In violation of any laws, rules, or regulations relating to federal or state healthcare reimbursement programs.

7.2.2. Request for Initiation of a Formal Corrective Action

a. Any of the following may request that corrective action be initiated:

1. An officer of the Medical Staff

2. The chair of any Department in which the Practitioner exercises Privileges

3. Any standing committee or subcommittee of the Medical Staff (including the MEC) or chair thereof

4. The Chief Medical Officer

5. The Chief Operating Officer

6. The Board or Board chair

b. All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. Such request must be supported by reference to the specific activities or conduct that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis therefore in its minutes.

c. The chair of the MEC shall promptly notify the Chief Operating Officer, in writing, of all requests for corrective action and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

7.2.3. MEC Action Upon Receipt of Request for Initiation of Formal Corrective Action

a. Upon receipt of a request for formal corrective action, the MEC shall act on the request.

b. The MEC may:

1. Determine that no corrective action is warranted and close the matter.

2. Determine that no corrective action is warranted but remand the matter for collegial intervention or informal remediation consistent with the applicable Medical Staff Policy.

3. Initiate a formal corrective action investigation.

7.2.4. Commencement of Formal Corrective Action

a. A matter shall be deemed to be under formal investigation upon determination by the MEC to initiate a corrective action investigation.

b. The affected Medical Staff Member shall be provided with written notice of a determination by the MEC to initiate a formal corrective action investigation.

7.2.5. Conducting a Formal Corrective Action Investigation

a. The MEC may conduct such investigation itself; assign this task to a Medical Staff officer, Section Chief or Department Chair, the Chief Medical Officer, or a standing or *ad hoc* Medical Staff committee; or may refer the matter to the Board for investigation and resolution.

b. The MEC may reasonably rely upon the findings of all prior Hospital or Medical Staff committees without conducting further inquiry.

c. This investigation process is not a "hearing" as that term is used in the Fair Hearing Policy and does not entitle the Medical Staff Member to the procedural due process rights provided in the Fair Hearing Policy.

d. The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation: a meeting with the Medical Staff Member involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of, or information relevant to, the events involved.

e. If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of its investigation, which may be reflected by minutes, to the MEC as soon as is practicable after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action, or no action at all, and the basis for such recommendations.

f. The MEC may at any time in its discretion, and shall at the request of the Board, terminate the investigative process and proceed with action as provided below.

7.2.6. MEC Action Following Completion/Receipt of Report

a. As soon as is practicable following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action.

b. The MEC's actions may include, without limitation, the following:

1. A determination that no corrective action be taken.

2. Issuance of a verbal or written warning or a letter of reprimand.

3. Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional practice or conduct but without requirement of prior or concurrent consultation or direct supervision.

4. Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the

Medical Staff Member's ability to continue to exercise previously exercised Privileges for a period of up to fourteen (14) days.

5. Imposition of a suspension of all, or any part, of the Medical Staff Member's Privileges for a period up to fourteen (14) days.

6. Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member's Privileges for a period up to fourteen (14) days.

7. Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member's ability to continue to exercise previously exercised Privileges for a period in excess of fourteen (14) days.

8. Recommendation of a suspension of all, or any part, of a Medical Staff Member's Privileges for a period in excess of fourteen (14) days.

9. Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member's Privileges for a period in excess of fourteen (14) days.

10. Recommendation of termination/revocation of all, or any part, of the Medical Staff Member's appointment and/or Privileges.

7.2.7. Adverse Recommendation. When the MEC's recommendation is Adverse (as defined in these Bylaws and the Fair Hearing Policy) to the Medical Staff Member, the Medical Staff President shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural due process rights contained in the Fair Hearing Policy. The Medical Staff President shall then hold the Adverse recommendation in abeyance until the Medical Staff Member has exercised or waived the right to a hearing and appeal after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board.

7.2.8. Failure by MEC to Act. If the MEC (a) refers the matter to the Board; or (b) fails to act on a request for corrective action within an appropriate time, as determined by the Board, the Board may proceed with its own investigation or determination as applicable to the circumstances. In the case of (b), the Board shall make such determination after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.

a. If the Board's decision is not Adverse to the Medical Staff Member the action shall be effective as its final decision and the Chief Operating Officer shall inform the Member of the Board's decision by Special Notice.

b. If the Board's action is Adverse to the Medical Staff Member, the Chief Operating Officer shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural due process rights set forth in the Fair Hearing Policy.

7.2.9. The commencement of corrective action procedures against a Medical Staff Member shall not preclude the summary suspension or automatic suspension or automatic termination of the Medical Staff appointment and/or all, or any portion, of the Member's Privileges in accordance with the applicable procedures set forth in this Article.

7.3. Summary Suspension

7.3.1. Grounds and Authority to Impose

a. Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect the life of any patient(s) or to reduce the substantial likelihood of imminent danger to the health or safety of any patient, employee, or other person present in the Hospital, any of the following have the authority to summarily suspend the Medical Staff appointment and/or all, or any portion, of the Clinical Privileges of such Practitioner:

1. Medical Staff President

2. Department Chair with approval of the Medical Staff President and CMO

3. Medical Executive Committee

4. Chief Operating Officer or CMO after conferring with the Medical Staff President or Vice-President

5. Board or its chair

7.3.2. A summary suspension is effective immediately. The person(s) or group imposing the summary suspension (if other than the Chief Operating Officer) shall immediately inform the Chief Operating Officer of the summary suspension and the Chief Operating Officer or the Medical Staff President shall promptly give Special Notice thereof to the Practitioner.

7.3.3. The Medical Staff President or applicable Department Chair or Section Chief shall assign a suspended Practitioner's patients then in the Hospital to another Practitioner with appropriate Privileges considering the wishes of the patient, where feasible.

7.3.4. As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC (if it did not impose the summary suspension) shall convene to review and consider the need, if any, for a professional review action (*i.e.*, formal corrective action) pursuant to Section 7.2. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in the Medical Staff Fair Hearing Policy (even if the involved Practitioner attends the meeting), and no procedural requirements shall apply.

7.3.5. The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board.

7.3.6. In the case of a summary suspension imposed by the Board, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

7.3.7. Not later than fourteen (14) days following the original imposition of the summary suspension, the Chief Operating Officer or the Medical Staff President shall notify the Practitioner, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board, of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or continued.

7.3.8. If a summary suspension remains in place for more than fourteen (14) days, the Practitioner shall be advised, by Special Notice, of the Practitioner's rights, if any, pursuant to the Medical Staff Bylaws and Fair Hearing Policy.

7.3.9. A summary suspension that is lifted within fourteen (14) days of its original imposition shall not be deemed an Adverse action for purposes of the procedural due process rights set forth in the Fair Hearing Policy.

7.4. Grounds for Automatic Suspension of Medical Staff Appointment and/or Privileges

7.4.1. The following events shall, upon occurrence, result in an automatic suspension or limitation of a Practitioner's Medical Staff appointment and/or Privileges, as applicable, without recourse to the procedural due process rights set forth in the Fair Hearing Policy.

a. License/Certificate to Practice

1. Whenever a Practitioner's license or certificate to practice is suspended, the Practitioner's Medical Staff appointment and Clinical Privileges shall be likewise automatically suspended.

2. Whenever a Practitioner's license or certificate to practice is limited or restricted by the applicable licensing or certifying authority, the Practitioner's Medical Staff appointment and Clinical Privileges shall be automatically limited or restricted in a similar manner.

3. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his/her Medical Staff appointment and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation.

4. Whenever a Practitioner's license expires solely as a result of the Practitioner's inadvertent failure to renew such license on a timely basis, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended subject to Section 7.5.1 (a)(2).

b. DEA Registration

If a Drug Enforcement Administration (DEA) registration number (or other authorization to prescribe controlled substances) is required for the Privileges granted:

1. In the event of action by the DEA or other controlled substances authority suspending a Practitioner's DEA registration number (or other authorization to prescribe controlled substances) the Practitioner's

Medical Staff appointment and Privileges shall be automatically suspended.

2. In the event of action by the DEA or other controlled substances authority restricting or imposing probation on a Practitioner's DEA registration number (or other authorization to prescribe controlled substances) the Practitioner's right to prescribe medications covered by the registration shall automatically and correspondingly be limited or made subject to the terms of the probation.

3. Whenever a Practitioner's DEA registration number (or other authorization to prescribe controlled substances) expires solely as a result of the Practitioner's inadvertent failure to renew such registration on a timely basis, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended subject to Section 7.5.1 (b)(2)

c. Professional Liability Insurance. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended subject to Section 7.5-1 (c). The Medical Staff Office shall be provided with a copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the Practitioner's non-compliance with the Hospital's Professional Liability Insurance requirements, any limitation on the new policy, and a summary of relevant activities during the period of non-compliance. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this provision.

d. Failure to Complete Electronic Health Record Training. A Practitioner's Privileges shall be automatically suspended for failure to successfully complete the Hospital's training with respect to use of the electronic health record.

e. Documentation of TB Test. Failure to adhere to tuberculosis screening requirements as set forth in the Hospital's Tuberculosis Exposure Control Plan shall result in automatic suspension of the Practitioner's Medical Staff appointment and Privileges.

f. Delinquent Medical Records. Whenever a Practitioner fails to complete medical records as provided for in applicable Hospital/Medical Staff policies, the Practitioner's Medical Staff appointment and/or Privileges shall be automatically suspended or limited to the extent and in the manner provided for in such Hospital/Medical Staff policies.

g. Federal Healthcare Program. Whenever a Practitioner is suspended from participating in a Federal Healthcare Program, the Practitioner's Medial Staff appointment and Privileges shall be automatically suspended.

h. Charges/Indictment. If a Practitioner is charged or indicted for: (i) a felony criminal offense; or (ii) a violent crime; or (iii) improper prescribing of a controlled substance or other serious offense that involves drugs; or (iv) a crime against a

child; or (v) a crime that prohibits practice at a children's hospital, the Practitioner's Medical Staff appointment and Privileges will be automatically suspended.

j. Immunizations/Health Screenings. Failure to provide documentation of required immunizations and/or health screenings (or an approved exemption) in accordance with the requirements set forth in applicable Hospital and/or Medical Staff policies will result in an automatic suspension of the Practitioner's Medical Staff appointment and/or Privileges subject to Section 7.5.1(g) below.

7.4.2. Impact of Automatic Suspension or Limitation of Medical Staff Appointment and/or Privileges

a. With the exception of Section 7.4-1 (f) regarding delinquent medical records, during such period of time when a Practitioner's Medical Staff appointment and/or Privileges are automatically suspended or limited, he/she may not, as applicable, exercise his/her appointment Prerogatives or any Privileges at the Hospital including, but not limited to, participating in on-call coverage, scheduling surgery, admitting patients, or otherwise providing professional care, treatment, and/or services at the Hospital.

b. A Practitioner whose Privileges are automatically suspended or limited pursuant to Section 7.4-1 (f) for delinquent medical records is subject to the same limitations except that such Practitioner may:

1. Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension/limitation of Privileges.

2. Attend to the management of patients under his or her care requiring emergency care and intervention.

3. Attend to the management of any patient under his/her care whose admission or outpatient procedure was scheduled prior to the effective date of the automatic suspension and which occurs within forty-eight (48) hours after the automatic suspension.

7.4.3. Action Following Imposition of Automatic Suspension

a. At its next regular meeting (or sooner if the Medical Executive Committee deems it appropriate) after the imposition of an automatic suspension, the Medical Executive Committee shall convene to determine if corrective action is necessary in accordance with the procedure set forth in Section 7.2.

b. The lifting of the action or inaction that gave rise to an automatic suspension of Medical Staff appointment and/or Privileges shall result in the automatic reinstatement of the Practitioner's appointment and/or Privileges, as applicable; provided, however, that the Practitioner shall be obligated to provide such information/documentation as the Medical Staff Office may reasonably request to assure that the situation that gave rise to the automatic suspension/limitation has

been appropriately resolved and that all information in the Practitioner's credentials file is current.

c. Written notification of an automatic suspension and of reinstatement of Medical Staff appointment and/or Privileges following an automatic suspension shall be given to the affected Practitioner by the Medical Staff President or Chief Medical Officer. The Medical Staff Office will notify, as applicable, the Medical Staff President, CMO, and the Practitioner's Department Chair/Section Chief of an automatic suspension of the Practitioner's Medical Staff appointment and/or Clinical Privileges and the automatic reinstatement thereof.

7.5. Grounds for Automatic Termination of Medical Staff Appointment and Privileges

7.5.1. Imposition of Automatic Termination. The following events shall, upon occurrence, result in an automatic termination of Medical Staff appointment and Privileges without recourse to the procedural due process rights set forth in the Fair Hearing Policy.

a. Licensure

1. Action by any applicable licensing authority terminating a Practitioner's professional license shall result in the automatic termination of the Practitioner's Medical Staff appointment and Privileges.

2. Whenever a Practitioner (whose Medical Staff appointment and Privileges were automatically suspended pursuant to Section 7.4.1 (a)(4) for an expired license) fails to renew his/her license within ninety (90) days after its expiration, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated as of the ninety-first (91st) day.

b. DEA Registration

If a DEA registration number (or other authorization to prescribe controlled substances) is required for the Privileges granted:

1. In the event of action by the DEA or other controlled substances authority revoking a Practitioner's DEA registration number (or other authorization to prescribe controlled substances), the Practitioner's Medical Staff appointment and Privileges shall automatically terminate.

2. Whenever a Practitioner (whose Medical Staff appointment and Privileges were automatically suspended pursuant to Section 7.4.1 (b)(3) for an expired DEA registration number or other authorization to prescribe controlled substances) fails to renew his/her registration within ninety (90) days after its expiration, his/her Medical Staff appointment and Privileges shall be automatically terminated as of the ninety-first (91st) day.

c. Professional Liability Insurance. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect for a period greater than thirty (30) days, during which time the Practitioner is automatically suspended pursuant to Section 7.4.1 (c), the Practitioner's Medical Staff appointment and Privileges shall automatically

terminate as of the thirty-first (31st) day. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

d. Federal Healthcare Program. Whenever a Practitioner is excluded from participating in a Federal Healthcare Program, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.

e. Plea of Guilty to Certain Offenses. If a Practitioner pleads guilty to, is found guilty of, or pleads no contest to: (i) a felony criminal offense; or (ii) a violent crime; or (iii) improper prescribing of a controlled substance or other serious offense that involves drugs; or (iv) a crime against a child; or (v) a crime that prohibits practice at a children's hospital, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.

f. Immunizations/Health Screenings. In the event that documentation of required immunizations and/or health screenings (or an approved exemption) is not provided within ninety (90) days following the date of an automatic suspension of Medical Staff appointment and/or Privileges pursuant to Section 7.4.1(j), then the Practitioner's Medical Staff appointment and/or Privileges shall automatically terminate as of the ninety-first (91st) day.

g. Board Certification. Unless a waiver is requested and subsequently granted, a Practitioner's failure to attain and maintain board certification in accordance with the requirements set forth in the Medical Staff Bylaws and Credentials Policy shall result in automatic termination of the Practitioner's Medical Staff appointment and/or Privileges.

7.5.2. The Medical Staff Office will notify, as applicable, the Medical Staff President, CMO and the Practitioner's Department Chair/Section Chief of an automatic termination of the Practitioner's Medical Staff appointment and/or Clinical Privileges.

7.6. Alternate Medical Coverage

7.6.1. Immediately upon the imposition of a summary suspension, automatic suspension, or automatic termination, the Chief Medical Officer, after consultation with the applicable Department Chair, shall have authority to provide for alternative medical coverage for the patients of the Practitioner who remain in the Hospital at the time of such summary suspension or automatic suspension/termination. The wishes of the patients shall be considered, when feasible, in the selection of such alternative Practitioner. The affected Practitioner shall confer with the covering Practitioner to the extent necessary to safeguard the patient(s).

7.7. Consistency of Action Between Hospital and Affiliate Hospital(s)

7.7.1. So that there is consistency between the Hospital and Affiliate Hospital(s) regarding corrective action and the status of medical staff appointment and privileges considering that the Hospital and the Affiliate Hospital(s) are part of the same healthcare system and that the Hospital and the Affiliate Hospital(s) have agreed to share information regarding appointment and privileges, the following automatic actions shall occur:

a. With the exception of an automatic suspension for delinquent medical records, if a Practitioner's appointment and/or Privileges are automatically suspended or automatically terminated, in whole or in part, at Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy.

b. If a Practitioner's appointment and/or privileges are summarily suspended or if a Practitioner voluntarily agrees not to exercise privileges while undergoing an investigation at Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the Practitioner's appointment and/or Privileges at Hospital and shall remain in effect until such time as Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.

c. If a Practitioner's appointment and/or privileges are limited, suspended, or terminated at Affiliate Hospital(s), in whole or in part, based on professional conduct or clinical competency concerns, the Practitioner's appointment and/or Privileges at Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy unless otherwise provided in the final decision at Affiliate Hospital(s).

d. If a Practitioner resigns his/her medical staff appointment and/or privileges or fails to seek reappointment and/or regrant of privileges at Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the Practitioner's Medical Staff appointment and/or Privileges at Hospital without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy.

e. If a Practitioner withdraws an initial application for medical staff appointment and/or privileges at Affiliate Hospital(s) for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to applications for Medical Staff appointment and/or Privileges at Hospital without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy.

ARTICLE 8 HEARING AND APPELLATE REVIEW PROCEDURES

8.1. Overview

8.1.1. Upon timely and proper request for a hearing by the affected Practitioner, the body that issued the Adverse recommendation or action (*i.e.,* the MEC or Board, as applicable) shall schedule a hearing.

8.1.2. The decision as to whether to utilize a hearing officer or a hearing panel (and selection of such hearing officer or hearing panel members) shall be at the sole discretion of the body whose Adverse recommendation or action triggered the hearing.

a. A hearing officer may be a Practitioner, an attorney, or other individual qualified to conduct the hearing. The hearing officer is not required to be a Medical Staff Member.

b. A hearing panel shall consist of not less than three (3) persons. The hearing panel members may either be Practitioners or individuals from outside of the Hospital, or a combination thereof. At least two (2) members of the hearing panel should be Practitioners.

8.1.3. The hearing will be conducted in a manner consistent with the then current requirements of the Health Care Quality Improvement Act, as amended from time to time, and as further detailed in the Fair Hearing Policy.

8.2. Medical Staff Fair Hearing Policy

8.2.1. The Medical Staff Fair Hearing Policy shall set forth additional information with respect to the Medical Staff hearing and appeal procedure.

ARTICLE 9 CONFIDENTIALITY, IMMUNITY, REPORTING, AND RELEASES

9.1. Special Definitions

9.1.1. For purposes of this Article, the following definitions shall apply:

a. Information means documentation of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communication, whether in written or oral form, relating to any of the subject matter specified in Section 9.5 of this Article.

b. Representative means the Board, Hospital, Medical Staff, and any agent (*e.g.*, Board members, Practitioners, APPs, Hospital employees, peer review committee member, *etc.*) authorized to perform specific Information gathering, analysis, use, or disseminating functions.

c. Third Parties means both individuals and organizations providing Information to any Representative.

9.2. Authorizations and Conditions

9.2.1. By submitting an application for Medical Staff appointment/reappointment and/or grant/regrant of Clinical Privileges and at all times during which a Practitioner holds Medical Staff appointment and/or Privileges at the Hospital, such Practitioner:

a. Authorizes Representatives to solicit, provide and act upon Information regarding the Practitioner's qualifications for Medical Staff appointment and/or Clinical Privileges and his/her professional practice.

b. Authorizes Third Parties to provide Information to Representatives regarding the Practitioner's qualifications for Medical Staff appointment and/or Clinical Privileges and his/her professional practice.

c. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative or Third Party who acts in accordance with provisions of this Article.

d. Acknowledges that the provisions of this Article are express conditions to his/her application for and exercise of Medical Staff appointment and/or Privileges at the Hospital.

9.3. Confidentiality of Information

9.3.1. Information with respect to any Practitioner submitted, collected, or prepared by any Representative of this Hospital or by any other health care facility or organization of health professionals or medical staff for the purpose of: evaluating, monitoring or improving the quality, appropriateness, and efficiency of patient care; evaluating the qualifications and performance (*e.g.*, conduct, clinical competence, *etc.*) of a Practitioner; acting upon matters relating to corrective action; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and

performed in accordance with the applicable standards of care; or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Such Information shall not be disclosed or disseminated to anyone other than a Representative or other health care facility or organization or medical staff engaged in an official, authorized activity for which the Information is needed, nor be used in any way except as authorized by these Bylaws, applicable Hospital/Medical Staff policies, or as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for formal corrective action pursuant to these Bylaws.

9.4. Immunity from Liability

9.4.1. For Action Taken. No Representative or Third Party shall be liable to a Practitioner for damages or other relief for any action taken or decision, opinion, statement, or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

9.4.2. For Gathering/Providing Information. No Representative or Third Party shall be liable to a Practitioner for damages or other relief by reason of gathering or providing Information, including otherwise privileged or confidential Information, concerning a Practitioner who is or has been an applicant for Medical Staff appointment and/or Privileges, or who is or has been a Member of the Medical Staff, or who did or does exercise Clinical Privileges at the Hospital provided that such Representative or Third Party acts within the scope of his/her duties as a Representative or Third Party and does not act on the basis of false Information knowing it to be false.

9.5. Activities and Information Covered

9.5.1. Activities. The confidentiality and immunity provided by this Article shall apply to all Information in connection with the activities of this Hospital or any other health care facility or organization of health professionals or medical staff concerning, but not limited to:

a. Applications for Medical Staff appointment and/or Privileges

b. Applications for Medical Staff reappointment and/or regrant of Privileges

c. Corrective action

d. Hearings and appellate reviews

e. Performance improvement/quality assessment/peer review activities

f. Utilization review/management activities

g. Any other Hospital, Department/Section, committee, or Medical Staff activities related to evaluating, monitoring, and maintaining quality and efficient patient care, clinical competency, and professional conduct.

9.6. Releases

9.6.1. Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with this Article, subject to such requirements as may be applicable under state and federal laws. Such releases will operate in addition to the provisions of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

9.7. Cumulative Effect

9.7.1. Provisions in the Medical Staff Bylaws and Policies and in the application or other Hospital or Medical Staff forms relating to authorizations, confidentiality of Information, and releases/immunity from liability shall be in addition to other protections provided by law and not in limitation thereof.

9.7.2. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE 10 GENERAL PROVISIONS

10.1. Conflict Management Process

10.1.1. Unless otherwise provided in the Medical Staff Bylaws or Policies:

a. In the event of a conflict between the MEC and the Medical Staff (on issues other than those involving individual Practitioner or APP matters), as reflected by a signed petition of not less than 25% of the Medical Staff Members eligible to vote on Medical Staff matters, a special meeting of the Medical Staff and MEC shall be convened to discuss issues of concern and seek resolution of the conflict.

b. In the event that the conflict cannot be resolved to the mutual satisfaction of the parties, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

10.2. Meetings

10.2.1. All Practitioners are encouraged to attend their Department/Section meetings and Medical Staff meetings.

10.2.2. Requirements with respect to Medical Staff, Department/Section, and Medical Staff committee meetings shall be set forth in the Medical Staff Organization Policy.

10.3. Practitioner Conduct and Impairment

10.3.1. Practitioners with Medical Staff appointment and/or Privileges at the Hospital 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 and in accordance with the Medical Staff Practitioner/APP Effectiveness Policy. 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.

10.3.2. The procedure for addressing Practitioner conduct matters is set forth in the Medical Staff Practitioner/APP Effectiveness Policy.

10.3.3. The procedure for addressing Practitioner/APP impairment is set forth in the Medical Staff Practitioner/APP Effectiveness Policy.

10.4. Medical History & Physical Examinations

10.4.1. All patients shall have a medical history and physical examination (H&P) completed and documented no more than thirty (30) days prior to, or within twenty-four (24) hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services (except in emergency surgical situations).

10.4.2. For an H&P that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting any changes in the patient's condition shall be completed within twenty-four hours after registration or inpatient admission, but prior to

surgery or a procedure requiring anesthesia services (except in emergency surgical situations).

10.4.3. The H&P (and any update thereto) shall be documented/placed in the patient's medical record within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services (except in emergency surgical situations).

10.4.4. The H&P (and any update thereto) shall be completed and documented by a Physician, an Oral Maxillofacial Surgeon, or other qualified licensed individual in accordance with applicable laws, rules, and/or regulations. Additional requirements regarding completion and documentation of the H&P are set forth in the Medical Staff Clinical Care Policy and/or other applicable Medical Staff/Hospital policies.

ARTICLE 11 ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS AND POLICIES

11.1. Overview

11.1.1. The Medical Staff has the responsibility to formulate, adopt, and recommend to the Board the Medical Staff Bylaws, and amendments thereto, which shall be effective when approved by the Board.

11.1.2. The Medical Staff hereby delegates to the Medical Executive Committee the responsibility to adopt and amend such Medical Staff Policies as may be necessary to implement the general principles set forth in these Bylaws and for the proper conduct of the Medical Staff.

11.1.3. Neither the Medical Staff or MEC, as applicable, nor the Board may unilaterally amend the Medical Staff Bylaws or Policies.

11.1.4. A proposal to amend the Medical Staff Bylaws or Policies may be offered by any Member of the Medical Staff eligible to vote at any meeting of the Medical Staff or to a member of the Medical Executive Committee. Nothing in the foregoing is intended to prevent a voting Member of the Medical Staff from proposing amendments to the Bylaws or Policies to the Board in writing or in a manner that is otherwise determined appropriate by the Board.

11.2. Adoption or Amendment of the Medical Staff Bylaws

11.2.1. The Medical Executive Committee shall review all proposals to adopt new Medical Staff Bylaws or to amend the current Medical Staff Bylaws.

11.2.2. The Medical Executive Committee's recommendation regarding adoption or amendment of the Medical Staff Bylaws will be presented to the voting Medical Staff Members by the Medical Executive Committee at any Medical Staff meeting. At least seven (7) days advance written notice of such meeting will be sent to all voting Medical Staff Members (and other individuals entitled to attend the meeting) and will include a copy of, or access to, the proposed Bylaws or amendment(s) thereto. Adoption or amendment of the Medical Staff Bylaws shall require approval by a majority of those Medical Staff Members eligible to vote who are present and voting at a Medical Staff meeting at which a quorum is present.

11.2.3. In the alternative, adoption or amendment of the Medical Staff Bylaws may be acted upon by written (*i.e.*, paper or electronic) ballot without a Medical Staff meeting. In such event, ballots will be provided to the Medical Staff Members eligible to vote in such manner as determined appropriate by the MEC and will include a copy of, or access to, the proposed Bylaws or amendment(s) thereto. Completed ballots must be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the deadline will not be counted. Adoption of the Bylaws or proposed amendment(s) in this manner requires the affirmative vote of a majority of the total number of ballots received by the specified deadline.

11.2.4. Adoption or amendment of the Medical Staff Bylaws will become effective as of the date approved by the Board. If the Board has determined not to accept a recommendation regarding the Medical Staff Bylaws submitted to it by the Medical Staff, the Joint Conference Committee shall be convened. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the Medical Staff representatives to discuss the rationale for the Medical Staff's position.

Following a recommendation from the Joint Conference Committee, the Board will take final action.

11.2.5. The MEC shall have the power to adopt such amendments to the Medical Staff Bylaws as are, in its judgment, non-substantive in nature such as technical modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, inaccurate cross-references, or to reflect changes in committee names. The action to amend may be taken by motion acted upon in the same manner as any other motion before the MEC. After approval, such amendments shall be communicated by written notice to the Medical Staff and to the Board. Such amendments shall be effective immediately and shall be deemed approved if not objected to by the Medical Staff or the Board within thirty (30) days of adoption by the MEC.

11.3. Adoption or Amendment of Medical Staff Policies

11.3.1. Adoption or amendment of Medical Staff Policies shall occur in one of the following ways at the discretion of the MEC:

a. By a majority affirmative vote of those MEC members eligible to vote who are present at an MEC meeting at which a quorum is present.

OR

b. By written (*i.e.*, paper or electronic) ballot without a MEC meeting. In such event, ballots will be provided to the MEC members eligible to vote in such manner as determined appropriate by the MEC and will include a copy of, or access to, the proposed Medical Staff Policy or amendment(s) thereto. Completed ballots must be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the deadline will not be counted. Adoption of a Medical Staff Policy or proposed amendment(s) in this manner requires the affirmative vote of a majority of the total number of ballots received by the specified deadline.

11.3.2. Any Medical Staff Member eligible to vote may raise a challenge to any Medical Staff Policy established by the MEC and approved by the Board. In order to raise such challenge, the Member must submit to the MEC a petition signed by not less than 25% of the total number of Medical Staff Members eligible to vote. Upon receipt of the petition, the MEC shall either (i) provide the petitioners with information clarifying the intent of such Medical Staff Policy; and/or (ii) schedule a meeting with the petitioners to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioners, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

11.3.3. Adoption or amendment of Medical Staff Policies is effective upon approval by the Board. If the Board has determined not to accept a recommendation regarding a Medical Staff Policy submitted to it by the MEC, the Joint Conference Committee shall be convened. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the Medical Staff representatives to discuss the rationale for the MEC's position. Following a recommendation from the Joint Conference Committee, the Board will take final action.

11.3.4. When the MEC adopts a Medical Staff Policy, or an amendment thereto, the MEC shall communicate such Policy, or amendment, to the Medical Staff following Board approval.

11.4. Resolution of Document Conflicts

11.4.1. All reasonable efforts shall be made to assure that the Medical Staff Bylaws and Policies, the Hospital's governing documents, and applicable Hospital policies are compatible with each other and compliant with applicable laws, rules, regulations, and accreditation standards.

11.4.2. If there is a conflict between the Hospital's governing documents or policies and the Medical Staff Bylaws and/or Policies the Hospital's governing documents/policies shall control; provided, however, that such conflict shall then be referred to the Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved.

11.4.3. If there is a conflict between the Medical Staff Bylaws and a Medical Staff Policy the Medical Staff Bylaws shall control; provided, however, that such conflict shall then be referred to the Medical Staff and MEC for resolution of the conflict.

11.5. Access to Current Medical Staff Documents

11.5.1. Access to the current Medical Staff Bylaws and Policies, and any amendments thereto, shall be made available, in such manner as determined by the MEC, to all Medical Staff Members and other Practitioners and Advanced Practice Providers with Clinical Privileges at the Hospital.

ADOPTION & APPROVAL

ADOPTED BY THE MEDICAL STAFF: October 25, 2024

APPROVED BY THE BOARD: October 25, 2024