MEDICAL STAFF BYLAWS

&

RULES & REGULATIONS

Bylaws Rev 6/2/14
Rules & Regulations Rev 9/12/11
MEDICAL STAFF BYLAWS
AND
RULES AND REGULATIONS
OF
BRANDON REGIONAL HOSPITAL

Foreword

Brandon Regional Hospital located at 119 Oakfield Drive, Brandon, Florida 33511 is a proprietary acute care, general hospital, owned and operated by Galencare, Inc., dba Brandon Regional Hospital, a Florida corporation (the “Corporation”).

Preamble

The organized medical staff is accountable to the governing body. Such self governance includes initiating, developing and approving medical staff bylaws and rules and regulations; approving or disapproving amendments to the medical staff bylaws and rules and regulations; selecting and removing medical staff officers; determining the mechanism for establishing and enforcing criteria and standards for medical staff membership; determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges; determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges; engaging in performance improvement activities.

The organized medical staff is responsible for structuring itself to endeavor to quality patient care, treatment and services.
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I. Name and Definitions

A. The name shall be the Medical Staff of Brandon Regional Hospital.

B. Definitions:

1. The term "Clinical Privileges" or "Privileges" means the permission granted to an individual to admit patients and to render specific diagnostic, therapeutic, medical, dental or surgical services.

2. The term "Corporation" means the corporation which owns and/or operates the Hospital.

3. The term "Executive Committee" or "Medical Executive Committee" means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

4. The term "Chief Executive Officer" means the individual appointed by the Corporation to provide the overall management of the Hospital.

5. The term "Ex-Officio" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

6. The term "Governing Body" means the Board of Trustees of the Hospital.

7. The term "Advanced Practice Professionals (APP)" means an individual, other than a Practitioner, whose patient care activities require him/her to exercise independent judgment within the areas of professional competence and to perform specified patient care services and who is qualified to render direct or indirect medical or surgical care under the supervision of a medical staff member with appropriate privileges. Advanced Practice Professionals (APP) shall include, without limitation, clinicians/practitioners, optometrists, physician assistants, therapists and anesthetists. Advanced Care Professionals (APP) may be independent practitioners, employees of the Hospital, or of members of the Medical Staff.

8. The term "Hospital" means Brandon Regional Hospital.

9. The term "Limited Health Practitioner" shall mean those practitioners whose scope of practice is anatomically limited by licensure law, except for oral surgeons, and shall include dentists, podiatrists and psychologists.

10. The term "Medical Staff" or "Staff" means the group of physicians duly licensed to practice medicine and surgery and dentists, podiatrists, and psychologists duly licensed to practice dentistry, podiatry, and psychology in the State of Florida who are privileged to attend patients in the Hospital.

11. "Medical Staff Year" means the period from January 1st through December 31st.

12. The term "Member" means a physician, dentist or podiatrist who has been granted membership and admitting and clinical privileges on the Medical Staff in accordance with these Bylaws.

13. The term "on call" shall mean the practitioner's ability to respond to the Hospital within thirty (30) minutes of call by the Hospital.
14. The term "Oral Surgeon" shall mean a duly licensed dentist who has successfully completed an approved oral surgery residency program.

15. The term "Physician - A doctor of medicine or osteopathy legally authorized to practice medicine/surgery by the State in which he performs such function or action.

16. The term "Practitioner" means a duly licensed dentist, podiatrist, or medical or osteopathic physician.

17. The term "attending physician" shall mean the physician or physician group with primary responsibility for clinical management of the patient.

18. The term "admitting physician" shall mean the physician of record responsible for the admission of the patient. This term is synonymous with attending physician or physician group until such time as the attending physician designation is formally transferred to another physician or physician group as outlined in these Bylaws.

19. "Federal Health Care program" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare/Champus and the Veterans programs.

20. "Ineligible Person" means any individual who is currently excluded from participation in any Federal health care program by a final action of the federal government and which exclusion has been published pursuant to the requirements of the healthcare Integrity and Protection Databank (HIPDB) or by the Office of the Inspector General of the Department of Health and Human Services (the OIG List).

II. Purposes

The purposes of this organization are:

A. To maintain a qualified Medical Staff whereby all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive quality medical care of the same level as all patients in the Hospital with the same problems.

B. To provide a high level of professional performance of all members of the Medical Staff through the appropriate delineation of clinical privileges for each practitioner and through planned systematic ongoing monitoring and evaluation of each Staff member's or Advanced Practice Professionals (APP)'s clinical and ethical performance in the Hospital.

C. To provide an appropriate atmosphere in which quality educational standards are maintained to afford continuous progress of the Medical Staff in professional knowledge and skill.

D. To provide a means of continuing accountability to the Governing Body for delivery of quality health care services and appropriate care in the Hospital.

E. To provide a means whereby issues of a medico-administrative nature concerning the Medical Staff, the Governing Body and the Corporation, through the Chief Executive Officer, may be discussed and resolved.

F. To promote, support and participate in medical programs designed and conducted to improve the general health of the community which the Hospital serves.

G. To promote and maintain accreditation of the Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
III. Medical Staff Membership

A. Nature of Membership

Staff membership is a privilege extended by the Hospital, and not a right of any physician, practitioner or other person. Membership and exercise of clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws. No person shall admit patients or provide services to Hospital patients as a Practitioner or Advanced Practice Professionals (APP) unless he is appointed to the Staff or has been granted privileges in accordance with the provisions outlined in these Bylaws. Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual’s Staff category or as afforded to Advanced Practice Professionals (APP) when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, “Membership in” is used synonymously with “appointment to” the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. A person may be a member of the Staff without having any clinical privileges. The granting of clinical privileges does not automatically confer Staff membership or appointment. The Board has determined the categories of health professionals eligible for Staff membership or clinical privileges, as defined in these Bylaws. All Medical Staff members and individuals with clinical privileges will enforce and comply with the Medical Staff Bylaws, Rules, Regulations and policies.

B. Eligibility and Qualification for Membership

1. Practitioners shall be eligible for membership on the Medical Staff only if they satisfy all of the following:
   a. Graduate of an approved and accepted medical, osteopathic, dental or podiatry school or of an accredited program for a terminal degree in psychology;
   b. Registered and possess a current, valid, and unconditional license to practice his/her profession in the State of Florida;
   c. Possession of a current, valid Drug Enforcement Agency (DEA) number, if applicable. The DEA must reflect an in-state address;
   d. Possession of a current UPIN number, if applicable, and NPI number. If UPIN/NPI number has not been received within 90 days, proof of application is required and approval of the application must be approved through the Medical Executive Committee;
   e. Live and practice closely enough to the Hospital to provide continuous care of his/her patients, (except as otherwise provided in these Bylaws);
   f. Provide documentation of professional education, training, experience, demonstrated competence, judgment, character, current capability and mental and physical ability to perform the services for which privileges are requested to have been granted, adherence to the highest ethics of his/her profession, professional and moral character and integrity, ability to work and cooperate with the Hospital personnel and staff members, and good reputation with sufficient adequacy to assure the Medical Staff and Governing Body that any patient treated by him/her in the Hospital will be given proper medical care with professional skill;
   g. Be or become board certified within five years of completion of residency training by an appropriate specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Board of Medical Specialties, the American Dental Board of Specialties and the American
Podiatry Association and remain Board Certified while on staff at Brandon Regional Hospital. (Unless there was a previous requirement for Board Certification in the specialty, this requirement is applicable only to those individuals who apply for initial staff appointment on, or after, the date this Policy is adopted (as of 12/07). All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their initial appointment.

h. In order for an applicant to qualify for memberships and to remain qualified for membership on the Medical staff, he/she shall show evidence of professional liability insurance with current and 24 months prior acts at a minimum of $250,000/$750,000 coverage, or limits as mandated by the current licensure law of the State of Florida, whichever is greater. All applicants for Staff membership will be required to show evidence of such minimum insurance coverage at the time application is made for appointment and reappointment as a pre-requisite to and condition of Staff membership. Such insurance shall be maintained during the time that he/she is a member of the Medical Staff. In addition, Medical Staff Members with active privileges in Obstetrics are required to participate annually in the Florida Birth Related Neurologic Injury Compensation (NICA) Fund to the extent that coverage is provided unless otherwise exempt by law.

i. The Practitioner is not an Ineligible Person.

j. National Practitioner Data Bank (NPDB) is queried at the time of initial medical staff appointment and initial granting of clinical privileges, at the time of expanding privileges or requesting to add new privileges, as well as at least every 24 months thereafter for health care practitioners granted clinical privileges;

k. any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;

l. relevant practitioner-specific data are compared to aggregate data, when available;

m. morbidity and mortality data, when available.

n. For initial appointments, a background check shall be obtained. If there is any information on the background check that is not clear, the applicant must explain in writing the circumstance that has been obtained on the background check. Any negative background check containing an indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving a) controlled substances; b) illegal drugs; c) Medicare, Medicaid or insurance or healthcare fraud; d) violence against another or e) related to the practice of healthcare professional or safety of patients and staff, even if not yet excluded, debarred or otherwise declared ineligible, must be fully explained to the satisfaction of the credentials committee before any consideration of the medical staff application.

2. No practitioner shall be automatically entitled to Medical Staff membership or to exercise admitting or clinical privileges in the Hospital merely because he/she is licensed to practice in the State of Florida, is a member of any professional organization, or has had or presently has, privileges at this or another hospital.

3. No aspect of Medical Staff membership or privileges shall be denied or affected because of sex, race, creed, color, religion, national origin, disability or any other criterion lacking professional or performance justification.
4. Application for membership on the Medical Staff shall constitute the applicant's certification that he/she has in the past, and his/her agreement that he/she will in the future, strictly abide by the Principles of Ethics of his/her professional association.

5. Appointments to the Medical Staff will also be guided by the ability of the Hospital, as determined by the Governing Body, to meet the present and future health care needs of the community it serves and specifically with reference to:
   a. Provision of continuity of service by the Medical Staff in light of projected resignations, transfers to inactive status and death of members;
   b. Provision of new professional skills as they may be developed by the evolution of medical science and specialty areas not adequately represented on the Medical Staff;
   c. Special interest in the Hospital and active participation in its programs, committee assignments and supervisory responsibilities;
   d. Availability of Hospital staff and facilities to provide quality health care and to maintain its plan of development including the mix of patient care services to be provided.

6. Assistant and Resident Physicians (House Physicians) may be used as the demands may warrant. They shall conform to the same standards of performance as the members of the Medical Staff. Their credentials and qualifications must first be reviewed by the Credentials Committee and the Executive Committee and approved by the Governing Body. They shall not be members of the Medical Staff.

7. Each person possessing privileges at the Hospital shall report to the Chief Executive Officer any of the following events immediately (immediately is defined as three (3) days) of the occurrence. Any applicant for privileges at the Hospital shall report the following events to the Chief Executive Officer with his or her application or, if occurring subsequent to the submittal of the application and prior to final disposition, to the Chief Executive Officer immediately (immediately is defined as three (3) days) of the occurrence. The Chief Executive Officer shall forward such information to the Executive Committee of the Medical Staff in a timely manner. The following events are reportable under this paragraph: (I) any suspension or revocation of the individual's license to practice medicine in any jurisdiction; (ii) any suspension, revocation or involuntary reduction or non-renewal of an individual's hospital privileges/membership and any resignation or voluntary relinquishment of privileges under threat of any such action; (iii) any denial of an individual's application for membership to any hospital staff; (iv) any disciplinary action initiated against the individual by any medical organization; (v) final judgments or settlements involving the individual in any such action; and (vi) any suspension, revocation or involuntary reduction or non-renewal of privileges or rights to participate in any health care organization or program, including health maintenance organizations, Medicare, Medicaid, Champus and any panel of providers established by third party payors; and (ix) any malpractice claims or actions made or filed against practitioner. The individual involved in any such events shall, upon request, appear before the Executive Committee of the Medical Staff and/or the governing Body, or their respective designees, and give an accurate explanation of the circumstances involving the individual in any of the foregoing events. Such appearance shall be informal and shall not be conducted or considered a hearing under Article VIII of these Bylaws.

C. Basic Obligations Accompanying Staff Appointment and/or the Granting of Clinical Privileges

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:
Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant’s performance; 

Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a member in good standing of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff; 

Discharge such Medical Staff, Department, Division, committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff; 

Participate in necessary training and utilize the CPCS (Meditech) to prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital; 

Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers; 

Participate in peer review, quality assurance, performance improvement, risk management, case management, resource management, and other review and improvement activities as requested; 

Participate in continuing education to maintain clinical skills and current competence; 

Notify and update the Medical Staff and Hospital immediately upon a change in any qualifications for membership or clinical privileges, as listed in these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person); 

During application process the medical staff may obtain an evaluation of the applicant’s performance by a consultant selected by the Hospital if the Hospital considers it appropriate. 

D. Ethics and Ethical Relationships 

1. The Code of Ethics as adopted or amended by the appropriate professional association and as provided in these Bylaws shall govern the professional conduct of the members of the Staff. Specifically, each applicant and member of the Staff pledges and agrees as follows: 

I authorize Brandon Regional Hospital to request, procure and review any information regarding my professional practice at any institution or from any individual or organization. I fully understand that any significant misstatements in or omissions from my application constitute cause for refusal of my application or for disciplinary action as provided in these Bylaws. I understand that inappropriate behavior as specified in the Bylaws can be grounds for disciplinary action. I agree to maintain in strictest confidence any information I may obtain as a result of my participation as a member of any medical staff committee. I agree to abide by the Medical Staff Bylaws, Rules and Regulations and policies, as amended and issued from time to time. I also agree to abide by applicable federal and state laws and regulations and the ethical rules of conduct that apply to me and my profession.
E. Joint Conference Committee

1. Whenever the Governing Body's decision is contrary to or notwithstanding a recommendation of the Executive Committee, the Governing Body shall submit the matter for recommendation to a joint conference committee ("Joint Conference Committee") consisting of three (3) members each from the Governing Body and the Executive Committee (such members shall be appointed by their respective chairperson) within fifteen (15) days of such decision. If there is no majority recommendation, the Joint Conference Committee shall provide a written report summarizing the different views of the Joint Conference Committee members. The Joint Conference Committee shall make its recommendation to the Governing Body within fifteen (15) days after receiving the matter. The Governing Body shall consider the recommendation and/or report from the Joint Conference Committee before making its final decision. The Governing Body shall communicate its final decision to the Executive Committee immediately after such has been made. Provided, however, that in any matter under these Bylaws pursuant to which the Governing Body may decide to refuse to confirm or approve the election or selection of, or to remove, any officer of the Medical Staff, including any Department, Section, or Division Chair, such final decision by the Governing Body shall only be made by a two-thirds (2/3) majority of the entire membership of the Governing Body.

F. Dues

1. The Executive Committee shall establish the annual dues of members of the Medical Staff which belong solely to the Medical Staff and which shall be used as determined by the Executive Committee to provide education, to support the medical library, to promote good relationships within the Medical Staff, to incentivize involvement in Medical Staff leadership and attendance at meetings of the Medical Staff and Medical Staff Committees, and for other purposes as the Executive Committee shall determine. Dues are due and payable on January 1st of each year. Annual dues shall be $250.00 annually with 50% credited to the subsequent year's dues when the medical staff member meets 50% attendance at assigned Medical Staff Committees. Members who have not paid their dues by February 1st are notified by letter that their dues are past due and that if they are not paid by March 1st, he/she shall be deemed to have resigned voluntarily from the Medical Staff. Reappointment may be granted only after application in the manner prescribed for an initial appointment.

IV. Procedure for Appointment and Reappointment

A. Application for Appointment

1. Applicants for appointment to the Medical Staff shall file with the Chief Executive Officer a written and signed application on a prescribed form furnished by the Hospital, together with his/her professional references.

a. The application shall require detailed information concerning:

   (1) the applicant's professional qualifications
   (2) the names and addresses of at least two (2) qualified persons with recent experience in observing and working with the applicant who can provide adequate written information regarding the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communications skills and professionalism.
   (3) the applicant's membership status and/or admitting and clinical privileges all hospital or institution (active or inactive).
   (4) whether his/her privileges or medical staff membership at any hospital or other facilities or organization or membership in local, state, or national medical societies, or his/her license to practice any profession in any jurisdiction, has ever been denied, revoked, reduced, withdrawn or voluntarily/involuntarily relinquished.
any professional liability actions involving the applicant including a
consent to release of information from his/her present and past
malpractice insurance carrier(s);

whether the applicant's narcotic license has ever been suspended,
revoked or voluntarily/involuntarily relinquished;

felony or professional practice related misdemeanor conviction or
nolo contendre or other guilty plea; and any suspension, sanction,
fine, exclusion or other restriction from participating in any private,
 federal or state health insurance program;

any suspension, sanction or other restriction from participating in
any private, federal or state health insurance program,

health status,

such other matters as may be deemed appropriate.

b. The applicant shall completely fill in all parts of the application or adequately
explain any failure to do so. Falsification of the application in any material
respect shall void the application and it shall be removed from
consideration.

2. As a condition of consideration for initial and continued appointment to the Medical
Staff, every applicant shall specifically agree to provide to the Medical Staff and the
Hospital, with or without request, any new or updated information that is pertinent to
the individual's professional qualifications, character, ethics, or any suspension,
sanction, fine, exclusion or other restriction from participating in any private, federal
or state health insurance program, or any sanction from a peer review organization.

3. Upon application for appointment to the Medical Staff, each applicant will receive a
copy of the Bylaws and Rules and Regulations and agrees:

a. to enforce and comply with the Hospital and Medical Staff Bylaws and Rules
and Regulations and the Hospital policies as amended from time to time;

b. to appear for interviews;

c. to authorize representatives of the Medical Staff and Governing Body to
consult with members of other Hospital Medical Staffs with which the
applicant has been associated and with others concerning the applicant's
professional and ethical qualifications, current competence, and character
for Staff membership and other factors, which may be considered in
evaluating his/her application, and authorizes such persons to release such
information; and

d. to consent to the inspection and copying of any and all records in the
possession of any such hospitals, persons, or other entities which would be
material in any evaluation of his/her qualifications and authorize anyone in
possession of such records to release them.

4. He/she releases from any liability all representatives of the Hospital and its Medical
Staff for their acts performed in good faith and without malice in connection with
evaluating the applicant and releases from any liability all individuals and
organizations who provide information to the Hospital in good faith and without
malice concerning the applicant's competence, ethics, character and other
qualification for Staff appointment and privileges, including privileges or confidential
information.

5. He/she agrees to sign the Attestation Statement as required by Medicare and any
other similar statements required by other payers.

B. Appointment Process

1. The applicant shall deliver an application to the Chief Executive Officer or designee
who shall, in a timely fashion, seek to collect or verify the references, and other
qualification evidence submitted. Verification of licensure, DEA, NPDB, OIG and
GSA lists shall be queried within 45 days prior to the Board receiving the application.
If there is a delay in the application, any of these query verifications that were verified more than 60 days before the Board approval shall be reverified. The Chief Executive Officer or designee shall promptly notify the applicant of any problem in collecting such information and it shall be the applicant's responsibility to obtain the information. If the application is not completed within six (6) months, it shall automatically be removed from consideration. When the information is collected and verified, the Chief Executive Officer or designee shall transmit the application and all supporting materials to the chairman of each department in which the applicant seeks privileges and to the Credentials Committee.

2. All reports and recommendations during the review process shall be submitted in writing on a form prescribed by the Executive Committee along with the application and all other documentation considered. Each report shall specify whether membership is recommended and, if so, the category and department and section assignment, the admitting and/or clinical privileges to be granted and any conditions to be attached to the appointment. The report shall state the reasons for each recommendation and support it with reference to the application and documentation considered.

3. Upon receipt, each department chairman or his/her designee shall promptly review the application and supporting documentation, interview the applicant, and transmit to the Credentials Committee a written report and recommendations according to Section B (2) of this Article. A department chairman may also recommend that the Credentials Committee defer action on the application. The report shall be transmitted to the Credentials Committee within fifteen (15) days of the Department Chairman’s receipt of the application.

4. Upon receipt, the Credentials Committee shall promptly review the application, the supporting documentation, the Department Chairman’s report and recommendations, and such other relevant information as may be available to it and it may interview the applicant. The Credentials Committee shall then transmit to the Executive Committee a written report and recommendations according to Section B (2) of this Article. The Committee may also recommend that the Executive Committee defer action on the application. The Credentials Committee shall submit its report to the Executive Committee not more than sixty (60) days after the receipt of the Department report.

5. At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Executive Committee shall consider the report and such other relevant information available to it and shall forward to the Chief Executive Officer for transmittal to the Governing Body its written report and recommendation according to Section B (2) of this Article. The Committee may defer action on the application for further consideration of the application but for not more than thirty (30) days after which time the Executive Committee must make a recommendation to the Governing Body to accept or reject the applicant. A minority report, supported by reasons and references, may also be submitted in writing with the majority report. Any member of the Medical Staff may offer information about the applicant to the Chairman of the Executive Committee.

6. The Governing Body, at its next regular meeting following receipt of the Executive Committee recommendation, shall consider the final report and recommendations of the Executive Committee. The Governing Body shall accept, reject or modify the report and recommendations and return their action to the Executive Committee stating the reasons, in writing, for such referral and setting a time limit within which an additional report shall be made to the Governing Body. At its next regular meeting after its receipt of the additional report, the Governing Body shall make a final decision. All decisions to recommend appointment shall delineate admitting and clinical privileges to be granted to the practitioner and assign the practitioner to a category, department and section of the Staff.
7. When the Governing Body has taken final action on any application for appointment to the Medical Staff, it shall, acting through the Chief Executive Officer, notify the Chairman of the Executive Committee and the applicant of the action taken. If the decision is adverse to the applicant, the Governing Body shall direct the Chief Executive Officer to notify the affected applicant by certified mail, return receipt requested, and the applicant shall be entitled to a hearing as prescribed in Article VIII, Section I of these Bylaws. The notice to the applicant shall advise the applicant of the reasons for the adverse recommendation, the right to a hearing and shall summarize the applicant's rights during the hearing.

8. Initial appointment to the Medical Staff shall be on a provisional basis for a period of one (1) year during which the member's professional and clinical performance and activities shall be observed and evaluated by the chairman of the department to which the member has been assigned or his/her designee. Provisional status may be extended for a period not to exceed one (1) additional year by the Medical Executive Committee upon written request and good cause shown by the provisional staff member.

C. Terms of Appointment

1. Appointments and reappointments shall be made by the Governing Body of the Hospital only after there has been a recommendation from the Executive Committee.

2. The Governing Body shall always have the right to suspend or revoke a member's membership or privileges whenever it deems it necessary for the good of the patients or Hospital, subject to Articles VII and VIII of these Bylaws.

3. Appointment to the Medical Staff shall confer on the appointee only such admitting and clinical privileges as have been granted by the Governing Body. An applicant for Staff membership must be able to render continuous and appropriate care and supervision of his/her patients, abide by the Bylaws and Rules and Regulations of the Medical Staff and Governing Body, agree to accept committee assignments and provide emergency care.

4. Except as otherwise recommended by the Executive Committee and approved by the Governing Body, all practitioners initially appointed to the Medical or Advanced Practice Professionals (APP) Staffs who change Staff departments or who are granted additional privileges shall complete a period of monitoring. Each department shall establish criteria for monitoring privileges exercised in it and shall provide a report of the monitoring results to the Executive Committee.

D. Acceptance to Staff Membership

1. No applicant shall be deemed to have been accepted for Medical Staff membership except upon application made and fully acted upon according to these Bylaws. Temporary privileges granted pursuant to these Bylaws shall not be deemed to confer upon any applicant any form of Staff membership or any rights and privileges of membership associated with the Medical Staff of the Hospital.

E. Reappointment Process

1. No member shall be automatically entitled to or have a vested right of renewal of membership and privileges.

2. Each member of the Medical Staff of all categories shall be subject to an evaluation one year from initial appointment to include the member's professional and clinical performance and activities, and thereafter a two year reappointment from the date of initial appointment. Should a member not advance from the Provisional/Active status the first year, a 12 month extension of provisional status may be granted. Reappointment from the initial date of appointment will take place not to exceed 24 months.
3. Except as otherwise provided in these Bylaws, no member of the Medical Staff shall be reappointed until his/her competency and qualifications have been demonstrated, and review shall include but shall not be limited to review of all criteria relevant to initial appointment as stated in Article IV, and:

   a. clinical privileges requested, with any basis for change;
   b. data issuing from the Medical Staff monitoring and evaluation process and citations, if any, by Medical Staff review committees, including quality care committees;
   c. professional performance, current competence and ability, judgment, and technical skills to perform the services for which privileges and medical staff membership are requested;
   d. professional ethics and conduct;
   e. continuing medical education since the previous appointment;
   f. conscientiousness in maintaining timely, accurate and legible medical records;
   g. compliance with the Medical Staff Bylaws and Rules and Regulations and the Hospital policies;
   h. cooperation with Hospital personnel and relations with other Staff members,
   i. utilization of Hospital facilities,
   j. general attitude toward his/her patients and the Hospital,
   k. malpractice claims and professional sanctions,
   l. any suspension, sanction fine, exclusion or other restriction from participating in any private, federal or state health insurance program, or any sanction from a peer review organization;
   m. whether the applicant's license to practice any profession, narcotic license, membership status or clinical privileges at all hospitals or institutions have ever been suspended, revoked or voluntarily/involuntarily relinquished;
   n. any felony or professional practice related misdemeanor,
   o. health status, and
   p. query of the National Data practitioner Bank (NPDB) and the Office of Inspector General (OIG).

4. All reports and recommendations during the reappointment process shall be submitted in writing on a form prescribed by the Executive Committee. Each recommendation shall state the Staff category to be assigned and delineate clinical privileges to be granted. If the recommendation is to (i) deny reappointment; (ii) reduce or increase clinical privileges; (iii) deny a requested increase in privileges or change of staff category, the reasons must be stated and supported with reference to documentation considered.

5. The Chief Executive Officer or designee shall provide each Staff member with a Reappointment application form. Each Staff member who desires reappointment shall, at least ninety (90) days before expiration of his/her appointment, send a Reappointment application to the Chief Executive Officer. Failure, without good cause, to file the application for reappointment shall be considered a voluntary resignation of membership at the expiration of the member's current term. The Chief Executive Officer or designee shall, in timely fashion, collect and verify the information on the application form and collect any other relevant materials or information, including information regarding the member's professional activities, performance and conduct in the Hospital. When the information has been collected and verified, the Chief Executive Officer or designee shall transmit the application and supporting materials to the chairman of each department in which the staff member requests clinical privileges.

6. Upon receiving a member's application for reappointment, each department chairman shall review and evaluate the member's Staff membership activities and clinical privileges for reappointment and data provided by the Medical Staff monitoring and evaluation process. The department chairman shall provide information concerning the member's professional performance, judgment, technical skill, ability to work with and cooperate with Hospital staff and personnel, current
competence and ability, and his/her opinion of the Staff member's physical and mental health status as it relates to ability to practice and exercise Hospital and clinical privileges in compliance with these Bylaws. The chairman shall submit a report of the findings to the Credentials Committee.

7. The Chairman of the Credentials Committee shall submit a written report and recommendation to the Executive Committee according to Section E (4) of this Article in sufficient time to allow review by the Executive Committee and the governing body before expiration of a member's term of appointment.

8. The Executive Committee shall submit a report and recommendation through the Chief Executive Officer to the governing Body according to Section E (4) of this Article in sufficient time to allow review by the Executive Committee and the governing body before expiration of a member's term of appointment.

9. If the Executive Committee's report to the Governing Body is adverse to the member, he/she shall have the right of hearing and appeal as set forth in these Bylaws. Unless the action taken is a summary suspension, the member's then current status on the Medical Staff with all rights and privileges shall remain in effect pending the outcome of any hearing and appeal, and final action by the Governing Body.

10. If a member's review is not completed within the time frame provided in this Section, the Review shall be completed as soon as possible and practical. In the interim, the member shall not be deemed reappointed, but shall retain his/her current membership and privileges until the process is completed, unless the applicant's membership and/or privileges are otherwise modified or revoked pursuant to these Bylaws. If the review is not completed due to the member's failure to provide requested information, the failure to provide such information shall be deemed a voluntary withdrawal of the application for reappointment and a voluntary resignation from the Medical Staff.

F. Leave of Absence

1. A Medical Staff member or Advanced Practice Professionals (APP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Chief Executive Officer. The request must state the beginning date and ending date for the period of leave desired, which may not exceed one year, and include the reasons for the request. The Medical Executive Committee shall review and recommend leave of absence requests to the Board of Trustees, but in extenuating circumstances such as military leave, the Chief Executive Officer and Chief of Staff shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Board of Trustees. During the period of leave, the Practitioner or APP shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the Medical Staff member or APP requesting the leave. A leave of absence shall be granted for Medical Staff members or APP in good standing, provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. Exceptions shall be allowed only in the event that a Medical Staff member or APP has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

MEDICAL LEAVE OF ABSENCE
A Medical Staff member or APP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or impairment. If an individual is unable to request a medical leave of absence because of a physical or psychological condition, the Chief of Staff or Chairperson of the individual's Department may submit the written notice on his/her behalf. A certified letter will be sent to
the individual informing him/her of this action. Reinstatement of membership status and/or clinical privileges may be subject to production of evidence by the individual that he/she has the ability to perform the clinical privileges requested.

MILITARY LEAVE OF ABSENCE
A Medical Staff member or APP may request and be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist shall submit a copy of deployment orders. Medical Staff members or APP who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

EDUCATIONAL LEAVE OF ABSENCE
A Medical Staff member or APP may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article Five of these Bylaws.

PERSONAL/FAMILY LEAVE OF ABSENCE
A Medical Staff member or APP may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor) or family reasons (e.g., maternity leave). Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

TERMINATION OF LEAVE
The Medical Staff member or APP on leave of absence may request reinstatement of Medical Staff membership and/or clinical privileges by submitting a written notice to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials, or if changes have occurred, a detailed description of the nature of the changes. The Staff member or APP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence has extended past the Practitioner's or APP's reappointment time, he/she will be required to submit an application for reappointment and the reinstatement shall be processed as a reappointment. A Practitioner or APP applying for reinstatement may apply for temporary privileges while the request for reinstatement is being processed, in accordance with temporary privilege process. The Chief of Staff will forward the request for reinstatement to the individual's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

FAILURE TO REQUEST REINSTATEMENT
Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and/or voluntary relinquishment of clinical privileges. A request for Medical Staff membership or clinical privileges subsequently received from a Medical Staff member or APP deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.
G. **Resignation from Medical Staff**

1. Any member who desires to resign from the Medical Staff must submit a letter of resignation through his/her assigned department chairman, to the Executive Committee of the Medical Staff and the Chief Executive Officer. The Executive Committee shall forward its recommendation to the governing Body, which shall take the final action.

2. A request for resignation shall not be considered until all obligations to the Hospital have been satisfactorily met by the member, including completion of all medical records, or arrangements satisfactory to the Hospital have been made.

3. Any member not complying with this Section shall be considered as having resigned from the Staff not in good standing and potentially reportable to regulation agencies.

H. **Reapplication to Medical Staff**

1. A practitioner who is denied membership or reappointment to the Medical Staff or whose membership is revoked, may not reapply to the Medical Staff for at least two (2) years after such action is considered final.

I. **Impaired Practitioner**

1. It is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a member of the Medical Staff or who has clinical privileges is suffering from impairment. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA). An "Impaired Individual" is one who is unable to perform the clinical privileges that have been granted with reasonable skill and safety to patients or perform other Medical Staff duties because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.

2. Treatment/Rehabilitation and Reinstatement Guidelines: If it is determined that the impaired individual suffers from an impairment that could be reasonably accommodated through rehabilitation or medical/psychological treatment.

The following are guidelines for rehabilitation or treatment and reinstatement:

3. As a condition of reinstatement, the impaired individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures set forth in these Bylaws. Minimally, licensure shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA list. The Hospital may also re-verify any other qualifications or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the impairment.
V. Clinical Privileges

A. Clinical Privileges Restricted

1. Medical Staff members or others practicing at Brandon Hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as otherwise provided in these Bylaws. The privileges shall only be within the scope of the licensure, certification or other legal limitations authorizing the practitioner's practice.

B. Application for Privileges

1. Applications for Staff appointment or reappointment must contain a request for the specific clinical privileges desired by the applicant supported by documentation of the applicant's relevant recent training and/or experience. Requests for privileges will be processed in the same manner as applications for appointment or reappointment to the Medical Staff.

C. Delineation of Privileges

1. Initial requests for clinical privileges shall be evaluated based upon the applicant's documented education, training, experience, references, specialty board qualifications, demonstrated current competence, ability, judgment, and licensure; the criteria developed by each department of the Medical Staff; and an appraisal by the service in which privileges are requested.

2. Upon reappointment, requests for clinical privileges shall be based on the member's training, experience, specialty board qualifications, competence, judgment and current capability which shall be evaluated by reviewing the practitioner's credentials, the peer review records and reports of the Medical Staff and observing the care rendered.

3. The practitioner applying for appointment or reappointment shall have the burden of establishing his/her qualifications and competence to exercise the clinical privileges requested.

D. Dentist Privileges

1. Privileges granted to dentists shall be based on their training, experience, demonstrated competence, judgment, current capability, and licensure. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical procedures and shall be under the overall supervision of the Chairman of the Department of Surgery.

2. Dental members of the Medical Staff may admit dental patients to the Hospital under the jurisdiction of the Department of Surgery or one of its subdivisions and shall designate in the patient's medical records upon admission a physician Staff member to have primary medical responsibility for the patient. All dental patients must have the same basic medical appraisal as patients admitted to other services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

Oral Surgeons who admit patients without medical problems may perform an admission history and physical examination and assess the medical risks of the procedure on the patient if they have privileges to do so. Criteria to be used in granting such privileges shall include, but shall not necessarily be limited to, the following: successful completion of a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education, and as determined by the medical staff, evidence of current competence to conduct such a history and physical and assessment. Patients with medical problems admitted to the Hospital by qualified Oral Surgeons shall receive
the same basic medical appraisal as patients admitted to other services. The responsible dentist shall take into account the recommendations of this consultation in assessing the procedure proposed and its effect on the patient. When there is significant medical abnormality, the final decision must be a joint responsibility of the dentist and the medical consultant. The dentist is responsible for that part of the history and physical examination related to dentistry. The designated physician member shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of dental patients.

3. Dentists may write orders and prescribe medications within the limits of their licensure and privileges granted pursuant to these Bylaws.

E. Podiatrist Privileges

1. Privileges granted to podiatrists shall be based on their training, experience, demonstrated competence, judgment, current capability and licensure. The scope and extent of their medical and surgical privileges shall be specifically delineated and granted in the same manner as all other medical and surgical procedures and shall be exercised under the overall supervision of the Chairman of the Department of Surgery.

2. A podiatrist member may admit patients to the Hospital under the jurisdiction of the Department of Surgery and shall designate a physician member with appropriate privileges to have primary medical responsibility for the patient in the medical record upon admission. All podiatry patients must have a history and physical appraisal performed by the physician member. The physician shall be responsible for the care of any medical problem that may be present on admission or arise during the patient's hospitalization and shall signify willingness to do so in the medical record. The physician and the podiatrist shall assess, with consultation if necessary, the overall risk and effect of surgery on the patient's health.

3. Podiatrists may write orders and prescribe medications within the limits of their licensure and privileges granted pursuant to these Bylaws.

F. Psychologist Privileges

1. Privileges granted to psychologists shall be based on their training, experience, demonstrated competence, judgment, current capability and licensure. The scope and extent of their clinical privileges shall be specifically delineated and granted in the same manner as for other practitioners and shall be exercised under the overall supervision of the Chairperson of Internal Medicine Department.

2. A psychologist member may not admit patients to the Hospital but may attend patients under the jurisdiction of the Department of Medicine. A physician member with appropriate privileges shall have primary medical responsibility for the patient in the medical record. All psychologists' patients must have a history and physical appraisal performed by the physician member. The physician shall be responsible for the care of any medical problem that may be present on admission or arise during the patient's hospitalization and shall signify willingness to do so in the medical record.

3. Psychologists may write orders within the limits of their licensure and privileges granted pursuant to these Bylaws.

G. Telemedicine Privileges

1. Practitioners who wish to provide telemedicine services, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws.
H. Advanced Practice Professionals (APP) Privileges

1. The Advanced Practice Professionals (APP) shall consist of persons trained and qualified in allied health disciplines who exercise independent judgment and provide special professional advice or specified services to Hospital patients, the medical or the administrative staffs.

2. Advanced Practice Professional shall be qualified by training, education and licensure appropriate for their special services and shall service within the scope of their recognized professional qualifications and skills.

3. Advanced Practice Professional shall be appointed or reappointed and granted privileges according to the procedures provided in Articles IV and V of these Bylaws. They shall be subject to the provisions of these Bylaws pertaining to Hospital privileges, duties and the ethical practice of their professions.

4. Advanced Practice Professional shall not be considered members of the Medical Staff and shall not be entitled to vote and to the rights of hearing or appeal afforded to the members of the Medical Staff. However, such individual shall have the right to appeal through the sponsoring physician to the Executive Committee whose recommendation will become final when approved by the Board of Trustees.

5. Advanced Practice Professional shall be assigned to a department of the Medical Staff by the Executive Committee and shall be responsible to the Chairman of that department.

6. Advanced Practice Professional may not admit or discharge patients. When requested by a patient's attending physician, they may within the scope of their privileges and these Bylaws and Rules and Regulations, attend that patient in the Hospital. The extent of the service shall be determined by the Staff and the attending physician who has the final responsibility for the welfare of the patient.

7. Notwithstanding anything to the contrary contained in this Section:
   a. Advanced Practice Professional employed by the Hospital shall be assigned to the appropriate department(s) or section(s) to perform such clinical duties as designated by the Hospital. The chairman or chief or his/her physician designee, of the department(s) or section(s) shall provide professional supervision of the Advanced Practice Professional services, as required. The Hospital shall otherwise be solely responsible for the control of and duties performed by the Advanced Practice Professional employed by the Hospital. Advanced Practice Professional who are employed or sponsored by members of the Medical Staff shall limit their practice to patients of their employer/sponsor, shall be assigned to the clinical section of their employer/sponsor, shall be directly responsible to their employer/sponsor, and shall relinquish privileges when the employer/sponsor relinquishes all privileges.
   b. The Hospital or the physician employer/sponsor may solicit from the appropriate department or section chairman or chief, and such department or section chairman or chief shall provide comments on the professional performance of such Advanced Practice Professional.

I. Temporary Privileges

Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of
his/her inability to obtain temporary privileges or because of any termination of
temporary privileges.

1. QUALIFICATIONS
Prior to temporary privileges being granted, an applicant for such privileges must
demonstrate that he/she possesses a government issued photo identification
document (i.e., state driver's license or passport), current license within this state, a
current and unrestricted DEA registration which reflects an in-state address, and,
evidence of current competence related to the temporary privileges requested, and
documentation of professional liability insurance coverage as required by the Board.

Physician Acknowledgement Statement must be completed and submitted as part of
the temporary privilege request.

Qualifications for temporary privileges shall be verified from a primary source or
designated agent of the primary source, and documented. The National Practitioner
Data Bank shall be queried prior to the granting of temporary privileges. Additionally,
the Hospital shall verify the applicant's status as an Ineligible Person. For this
purpose, the applicant shall provide his/her Medicare UPIN, if applicable, and the
NPI number, and the Hospital shall check the OIG Sanction Report and the GSA
List. If the applicant is excluded from such participation, temporary privileges shall
not be granted; any exclusion subsequent to having been granted temporary
privileges shall result in immediate termination of such privileges. When applying for
temporary privileges, each applicant shall agree to be bound by the Medical Staff
Bylaws, Rules and Regulations, departmental rules and regulations, and applicable
Hospital policies.

2. CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES
Temporary privileges may be granted by the Chief Executive Officer upon receiving a
recommendation from the appropriate department chairperson and/or Chief of Staff
under the conditions noted below. Individuals practicing based on temporary
privileges shall be acting under the supervision of the chairperson of the department
to which he/she is assigned. All temporary privileges shall be time-limited, as
specified for the type of temporary privileges listed below. Temporary privileges shall
automatically terminate at the end of the specific period for which they were granted,
without the Hearing and Appeal rights set forth in these Bylaws. Temporary
privileges shall be specifically delineated, and may include the privilege to admit
patients.

a. Care of Specific Patient(s):
Temporary privileges may be granted on a case-by-case basis when an
important patient care need justifies the authorization to practice. After receipt of
a written request for temporary privileges, temporary privileges may be granted
to a Practitioner who has a specific skill not possessed by a privileged
Practitioner, and the specific skill is needed by a specific patient, authorization
may be granted to provide care for that specific patient. Temporary privileges
granted under this condition shall not exceed the length of stay of the specific
patient or one hundred and twenty (120) consecutive days, whichever is less.

b. Pendency of Application:
After receipt of completion application for Medical Staff Membership, as defined
in the Bylaws, which will include a written request for temporary privileges, an
applicant, may be granted temporary privileges while his/her application undergoes final approval process. Temporary privileges granted under this
condition shall not exceed one hundred and twenty consecutive days (120). An
applicant waiting for final Board of Trustee approval who has been
recommended by the Medical Executive Committee, shall be eligible for
temporary privileges only after meeting the following criteria:

a) Submittal of a completed application;
b) There are no current or previously successful challenges to licensure;
c) There are no adverse membership actions at another hospital; and there are no adverse actions against the applicant's privileges at another hospital.

c. **Locum Tenens:**
Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice. A Practitioner who has been hired to substitute for a member of the Medical Staff, who is temporarily unable to provide services, due to the medical staff member being temporarily absent from his/her practice because of vacation, illness, military service, or attendance at a medical post-graduate education course, may be granted temporary privileges in order to fulfill an important patient care need that would be created by the Medical Staff member's absence and could not otherwise be met by the existing members of the Medical Staff. The locum tenens Practitioner shall not be granted temporary privileges that are in excess of those granted to the Medical Staff member being temporarily replaced. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days or the term of absence of the Medical Staff member, whichever is less.

J. **Disaster Response and Recovery:**
Potential disaster situations shall be described in the Hospital Emergency Operations Plan and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster. Upon activation of the Hospital's Emergency Operations Plan and in a situation in which the Hospital is not able to meet immediate patient needs, temporary disaster privileges may be granted to an appropriately qualified Practitioner based upon the needs of the Hospital to augment staffing due to the disaster situation.

Privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan (EOP), upon recommendation by the Chief of Staff or the EOP designated Medical Staff Director. All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs. Approvals shall be documented in writing.

The Chief of Staff or the EOP designated Medical Staff Director shall also assign a Member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges, through direct observation, mentoring, or clinical record review. Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage.

Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recovery period or one hundred and twenty (120) consecutive days, whichever is less.

Temporary disaster privileges may be granted upon presentation of a government-issued photo identification and any of the following, and shall be verified as soon as the immediate disaster situation is under control, using a process identical to granting temporary privileges for an immediate patient care need, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents
to the organization, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours.

A current picture identification card from a healthcare organization that clearly identifies professional designation;
A current license to practice in the State of Florida
Primary source verification of the license; or
Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group; or
Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or
Presentation by a current hospital or medical staff Member(s) with personal knowledge regarding the practitioner’s identity.

The following order of preference should be used in granting temporary disaster privileges:

a) Expert Practitioners from government agencies and medical staff members from other HCA hospitals

b) Volunteer Practitioners sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or medical staff Member(s) with personal knowledge regarding the practitioner’s identity

c) Volunteers from the community or surrounding areas

If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.

Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff Member if possible, with whom to collaborate in the care of disaster victims.

The Medical Staff shall oversee the professional practice of volunteer Practitioners, either by the direct supervision or mentoring provided by the Medical Staff member assigned to the volunteer practitioner, or when a medical staff member is not available to be assigned, then by medical record review to be performed as designated by Chief of Staff or Medical Executive Committee.

The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the Chief of Staff or the EOP designated Medical Staff Director.

In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated.

When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.
K. Emergency Privileges
In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff Member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

VI. Categories of the Medical Staff

A. Medical Staff

1. The Medical Staff shall be divided into the following categories: Provisional/Active, Active, Ambulatory, Courtesy, Consultant, Honorary, and Emeritus Staff.

B. Provisional/Active Staff

1. All initial appointments to or reassignments to any category of the Medical Staff shall be provisional for at least 12 months, except under unusual circumstances, and may be extended for up to an additional 12 months. During the provisional period, the member's professional and clinical performance and activities shall be observed and evaluated by the chairman (or his/her designee) of the department to which the member is assigned to determine eligibility for active courtesy or consulting status and exercising the admitting and clinical privileges granted to them.

2. If at the end of the provisional period, the member does not qualify for active status, the member may be reassigned to the previous category or his/her membership and privileges may be terminated subject to the right of hearing and appeal.

3. Provisional/Active members shall not be eligible to vote or hold office but shall pay dues and serve on Medical Staff committees, except Executive, Credentials and Nominating.

4. The Provisional/Active members shall provide on the Emergency Room On Call Service for their respective specialty unless other arrangements have been made. Changes will be made in writing to the Medical Staff Office.

5. Provisional/Active members shall have a minimum of 12 patient encounters per year.

6. Upon satisfactory completion of their Provisional/Active year, physicians under certain circumstances and based on physician specialty, a request may be made for Courtesy or Consulting privileges as recommended by the Medical Executive Committee.

C. Active Staff

1. Physicians who have satisfactorily completed their Provisional/Active year shall serve a year on the Active Staff prior to consideration for a change in their staff category.

2. The Active Staff shall consist of practitioners who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital, who live and practice within a reasonable distance from the Hospital in order to provide continuous care and supervision of their patients, and who assume active participation in the prescribed duties and functions of the Medical Staff, and otherwise meet the qualifications as prescribed in these Bylaws, including the application.
3. Members of the Active Staff shall be eligible to vote, hold office, and serve on Medical Staff committees. They shall be responsible to perform Staff assignments, and pay dues. Limited Health Practitioners may not hold office or chair standing committees.

4. Members of the Active Staff shall retain full responsibility within their area of professional competence for the continuous care and supervision of their patients in the Hospital, or arrange a suitable alternative (as approved by the appropriate department chairman) for such care and supervision. Active Staff members shall actively participate in quality assurance activities required of the Staff, and they shall faithfully discharge all Staff functions as may be required from time to time.

5. Active Staff members shall be given primary consideration for available beds and ancillary services for their patients where there is a choice in which no harm can result to a patient.

6. Active Staff members shall provide service on the Emergency Room On Call Services for their respective specialty unless other arrangements have been made. Changes will be made in writing to the Medical Staff Office. Active Staff members may act as consultants if granted appropriate privileges.

7. Active Staff members shall have a minimum of 12 patient encounters per year.

D. **Courtesy Staff**

1. The Courtesy Staff shall consist of members who only occasionally admit patients to or perform procedures in this Hospital, are located closely enough to the Hospital to provide continuous care and supervision to their patients, and are on the Active Staff in good standing at another Hospital which is located closely enough to allow the member to service patients at both Hospitals.

2. Members of the Courtesy Staff shall be privileged to have a total of twelve (12) inpatient and outpatient "admissions", procedures, and consults per year which include catheterization laboratory procedures, surgical suite procedures and endoscopy room procedures. Such limitation would exclude Radiologists, Pathologists, and Emergency Medicine physicians. The Board of Trustees approval, upon recommendation of the Executive Committee, may waive the twelve procedure limit when necessary to fill a clinical specialty need within the hospital.

3. Members of the Courtesy Staff shall not be eligible to vote or hold office, may not take Emergency Room On-Call, unless directed to do so by the Executive Committee, but shall pay dues and may be assigned to serve as members of Medical Staff Committees as determined by the Chief of Staff.

4. Members of the Courtesy Staff who signify a willingness to advance to Active Staff membership shall be considered as provided in Articles IV and V of these Bylaws.

E. **Consulting Staff**

1. The Consulting Staff shall consist of members representing selected specialties or medical abilities who are willing to accept such appointment. These practitioners are not required to live or practice close to the Hospital.

2. Members of the Consulting Staff may not admit patients or perform more than 12 procedures a year, shall pay dues, and shall not be eligible to vote, hold office or may not take Emergency Room On-Call, unless directed to do so by the Executive Committee. The Board of Trustees approval, upon recommendation of the Executive Committee, may waive the twelve procedure limit when necessary to fill a clinical specialty need within the hospital. They may serve as non-voting members of Hospital committees.
3. Members of the Consulting Staff who signify a willingness to advance to Active Staff membership shall be considered as provided in Articles IV and V of these Bylaws.

F. Ambulatory Staff

1. The Ambulatory Staff category shall consist of Practitioners who do not practice in the Hospital but still desire to maintain medical staff appointment to provide continuity of care to their patients or to satisfy a criterion of medical staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s).

2. The Ambulatory Staff category is a membership-only category of the Medical Staff with no clinical privileges, and limited medical staff responsibilities and prerogatives. As Members of the Medical Staff, Ambulatory Staff shall be fully credentialed and shall be granted membership based on a recommendation by the Medical Staff, with approval by the Governing Body. Since no clinical privileges are granted, Ambulatory Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

3. Members of the Ambulatory Staff may visit their hospitalized patients, and review their patients’ medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures. Ambulatory Staff shall not be eligible to vote or hold office within the Medical Staff organization. They shall not be required to carry malpractice insurance, however they shall be responsible to pay yearly medical staff dues.

4. Each Member of the Ambulatory Staff shall discharge the basic obligations of staff members as required in these Bylaws; but they shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required. Each Member of the Ambulatory Staff shall establish appropriate referral and coverage arrangements with an Active Staff Member for the medical care of his/her patients that require Hospital services.

G. Honorary Staff

1. The Honorary Staff shall consist of members who have been recognized for their noteworthy contributions to the Hospital, outstanding reputation or achievement or long-standing service to the Hospital. These members shall not be required to live or practice close to the Hospital unless they admit patients.

2. Members of the Honorary Staff shall not be eligible to vote, hold office, or be required to pay dues.

3. Honorary Staff members with appropriate clinical privileges may attend to or consult on patients in the Hospital.

H. Emeritus Staff

1. Emeritus Status shall consist of members who are no longer active medical staff members and are deemed worthy of emeritus status positions by the Executive Committee and Board of Trustees. This staff status represents those individuals who have retired from active practice in good standing and supported the hospital and medical staff during their active tenure.

2. Emeritus Status members shall not be eligible to admit patients, be granted clinical privileges, vote, hold office, or serve on standing medical staff committees.
3. Emeritus Status members shall not be required to pay dues, maintain current medical licensure, liability insurance coverage, or DEA certification.

VII. Disciplinary Action

A. Disciplinary Action

1. Disciplinary action against any member of the Medical staff may be requested by the Chief of Staff, Department Chairman, Chairman of any standing committee, the Chief Executive Officer or the Governing Body. All requests for disciplinary action shall be addressed in writing to the Chairman of the Executive Committee and shall refer to the specific activities or conduct which constitutes the grounds for the request. The Chairman of the Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for disciplinary action, and shall continue to keep him/her fully informed of any action taken. Initiation of disciplinary action shall not preclude imposition of a summary suspension under Section B.

For clarity and not in any way a limitation of the preceding paragraph, in the event that a Hospital employee or the member of any Hospital or Medical Staff committee has information regarding the conduct, performance, or competence of a member of the Medical Staff, such person shall report the information in writing to the Chief of Staff, Department Chairman, Chairman of any standing committee, the Chief Executive Officer or the Governing Body, as set forth above. No investigation or corrective action with respect to any such conduct, performance, or competence of a member of the Medical Staff shall take place except in strict compliance with the provisions of this Article VII.

2. Grounds for requesting disciplinary action of Medical Staff membership or privileges shall include, but not be limited to the following:

   a. A member's professional performance or professional, ethical or moral activities or conduct which are reasonably believed to be inconsistent with the generally recognized professional standards or aims of the Medical Staff, or be disruptive of Hospital operations or to reflect negatively upon the reputation of the Medical Staff, or detrimental to patient safety or quality of patient care in the Hospital.

   b. Engaging in unethical practice.

   c. Conviction of a felony.

   d. Failure to maintain adequate medical records, as determined by any state or federal law, rule or regulation.

   e. Intentional breach of patient confidentiality.

   f. Any violation of the Bylaws and/or Rules and Regulations of the Medical Staff or current Hospital policies.

   g. The practitioner is or becomes an Ineligible Person.

3. A requirement for monitoring or supervision of a practitioner may be imposed at any time, shall not be considered a disciplinary action and shall not entitle a member to a hearing or appellate review.

4. When the disciplinary action is requested, the Executive Committee shall either conduct an investigation through an Ad Hoc Committee appointed by the Chairperson or promptly submit such request to the Chairperson of the Department in which the member has privileges. Upon receiving such a request, the appropriate Chairperson or Ad Hoc Committee shall immediately conduct a detailed investigation.
of the matter. If an investigation is initiated, the affected member shall be notified and advised of the general nature of the complaint. A report of the findings and recommendations of the Chairperson or Ad Hoc Committee shall be made to the Chairperson of the Executive Committee within ten (10) days after the Department Chairperson’s or Ad Hoc Committee’s receipt of the request. Before the Department Chairperson or Ad Hoc Committee makes his/her report, if the affected member requests, he/she shall be permitted to appear before the Chairperson or his/her designee(s) or Ad Hoc Committee, be informed of the general nature of the complaint against him/her, and be permitted to make a statement on his/her behalf. This appearance shall constitute an interview and shall not be a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such appearance shall be made by the Chairperson or Ad Hoc Committee and included with his/her report to the Chairperson of the Executive Committee. A copy of such report will be made available to the member.

5. The Executive Committee shall consider the report from the department Chairperson or Ad Hoc Committee within ten (10) days after receiving it. If the report recommends suspension, reduction or revocation of membership or privileges on the Medical Staff, the member may be requested to appear before the Executive Committee before it acts on such report. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such appearance shall be made by the Executive Committee.

6. The member upon receiving the notice of a recommended disciplinary action may waive all further proceedings as outlined herein and request a final hearing before the Governing Body. Such a request shall be deemed a waiver of any further rights to hearing procedures and appeals according to these Bylaws. Such waiver shall be in writing to the Chief Executive Officer within fourteen (14) days after receipt of such notice.

7. The action of the Executive Committee may take the form of recommending: a letter of warning, admonition, or reprimand; reduction, suspension, or revocation of clinical privileges; terms of probation, or suspension or revocation of membership on the Medical Staff. Only those actions described in Article VIII, Section B shall entitle the member to the rights of hearing and appeal. Any other adverse action(s) shall entitle the member to an interview with the Executive Committee before it sends its recommendation to the Governing Body. Notice of the recommended disciplinary action shall be given to the affected member within three (3) days after the Executive Committee action. All recommendations of the Executive Committee shall be subject to approval or modification by the Governing Body.

B. Alternatives to Corrective Action

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts the right to a Hearing and Appeal, and shall not require reporting to the state licensing board or the NPDB, except as otherwise provided in these Bylaws. Alternatives to corrective action may include:

a) Informal discussions or formal meetings regarding the concerns raised about conduct or performance, included within this section that may be taken to address disruptive conduct;

b) Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

c) Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

d) Suggestions or requirements that the individual seek continuing education, consultations, or other assistant in improving performance;
e) Warnings regarding the potential consequences of failure to improve conduct or performance: and/or
f) Requirements to seek assistance for impairment, as provided in these bylaws and medical staff policy and procedure.

C. Summary Suspension

1. Upon a determination that immediate action is required, the Chief of Staff, any Department Chairperson, the Chief Executive Officer, and the Executive Committee of either the Medical Staff or the Governing Body shall each individually have the authority to summarily suspend all or part of a member's admitting and/or clinical privileges and membership. Such summary suspension shall be based on the need to protect or reduce the substantial and imminent likelihood of significant danger to the life, health or safety of any patient, employee or other person and shall become effectively immediately upon imposition. Written notice of the summary suspension shall be given promptly to the affected member, the Governing Body, the Executive Committee and the Chief Executive Officer.

The notice of the summary suspension shall constitute a request for disciplinary action and the procedures in Section A, Paragraphs 4-7 of this Article shall then be followed. The notice to the affected members shall also conform to Article VIII, Section C (1).

2. As soon as practicable but not later than seven (7) business days after imposition of the summary suspension, the Executive Committee shall convene to review the summary suspension. The affected member may, upon request, appear at the meeting of the Executive Committee to make a statement concerning the summary suspension, on such terms and conditions as the Executive Committee may impose. This meeting shall constitute only an interview and not a "hearing" within the meaning of Article VIII. The Executive Committee may recommend continuation or termination of the summary suspension or modification of its terms.

3. Unless the Executive Committee recommends termination of the summary suspension, the terms of the summary suspension as continued or modified by the Executive Committee shall remain in effect pending the disciplinary process and any hearing and appellate review afforded under Article VIII. If the Executive Committee recommends termination of the summary suspension, the suspension shall be lifted pending a final determination of the disciplinary action by the Governing Body. The final result of the disciplinary process shall substitute for the summary suspension.

4. Immediately upon the imposition of a summary suspension, the Chief of Staff in consultation with the appropriate Department Chairperson, shall have authority to provide for alternative medical coverage for the patients of the suspended member in the Hospital at the time of such suspension. The wishes of the patient shall determine, if possible, the selection of such alternative member.

D. Automatic Suspension

1. Medical Records: When a member fails to complete medical records within the time prescribed by the Medical Staff Rules and Regulations he/she shall be given a warning. If the member fails to complete the medical records within fifteen (15) days after receiving the warning, an automatic temporary suspension in the form of withdrawal of admitting privileges and scheduling elective surgery shall be automatically imposed by the Chief Executive Officer and shall remain in effect until such medical records are complete; however, privileges will be granted to fulfill obligations of the ER Call Schedule. Failure to complete the records within six (6) months after receiving a warning shall be deemed a voluntary resignation of the member's Medical Staff membership and privileges. Any practitioner suspended
three (3) times within any twelve (12) month period for delinquent records shall be subject to disciplinary action.

2. Licensure: Action by the State Board of Medical Examiners revoking or suspending a member’s license, or failure to maintain a current license, shall constitute grounds for the Chief of Staff or the Chief Executive Officer to revoke or suspend respectively automatically all of the member’s admitting and clinical privileges, or membership at the discretion of the Chief of Staff or Chief Executive Officer. If the member has been suspended and his/her license is not reinstated in good standing within one (1) year, it shall be deemed a voluntary resignation of the member’s Medical Staff membership and privileges.

3. Controlled Substances: Upon revocation or suspension of a member’s DEA Certificate, the member’s right to prescribe medications covered by the certificate shall be automatically suspended immediately for the duration of such suspension or revocation.

4. Malpractice Insurance: If a member fails to maintain the minimum professional liability insurance required as a qualification for membership, his/her membership and admitting and clinical privileges shall be automatically suspended until he/she provides evidence of such minimum insurance coverage. Failure to provide evidence within six (6) months after the suspension shall be deemed a voluntary resignation of Medical Staff membership and privileges.

5. Conviction of a Felony: A member who has been convicted of a felony shall be automatically suspended from membership pending an investigation under this Article. If the conviction is upheld, the member shall be deemed to have voluntarily resigned from the Medical Staff.

6. The Chief of Staff, with the cooperation of the Chief Executive Officer, shall enforce all automatic suspensions.

7. A member whose membership or privileges are automatically suspended or revoked under this Section shall have no right to a hearing and appellate review as provided in these Bylaws.

VIII. Hearing and Appellate Review Procedure

A Definitions and Preamble

1. Except as provided in Section I of this Article, only members of the Medical Staff shall be entitled to the hearing and appellate review procedure provided in this Article.

2. A member shall be entitled to only one hearing and one appellate review before receiving a final determination.

3. The Executive Committee and the Governing Body shall act on all recommendation(s) and report(s) described in this Article not later than at the first regular meeting following their receipt of such recommendation(s) or report(s).

4. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competence and conduct.

5. In event of an adverse action or recommendation, the member shall exhaust all hearing and appeal procedures afforded by these Bylaws before resorting to any legal action on either procedural or substantive grounds. If the member takes legal action and does not prevail, he/she shall bear the legal costs (including reasonable attorneys’ fees) incurred by the Hospital in defending such legal action.
6. All hearings and appellate reviews shall be conducted according to the procedural safeguards set forth in this Article to assure that the affected member is accorded all rights to which he/she is entitled.

7. Definitions:
   a. Notice: All notices and requests provided for during the hearing and appellate review process shall be made in writing through the Chief Executive Officer by certified mail, return receipt requested, or by personal delivery.
   b. Date of Notice: Shall mean the date on evidence of mailing the notice or delivery of any other written communication.
   c. Computation of Time: For the purposes of this Article, the day of mailing of notice or delivery of any other communication shall not be included in the computation of time. The last day of the time computed shall be included. If the time period is seven (7) days or less, the computation shall be business days; if the period is more than seven (7) days, the computation shall be calendar days. If the last day is a Saturday, Sunday or legal holiday, the period shall run to the next business day.

B. Right of Medical Staff Member to Hearing
   1. Except as otherwise specified in these Bylaws, any one or more of the following or recommended actions of the Executive Committee or proposed action of the Governing Body shall constitute grounds for a hearing:
      a. denial of requested advancement in staff membership status, or category.
      b. denial of medical staff appointment or reappointment.
      c. demotion to lower medical staff category or membership status.
      d. suspension or revocation of some or all clinical privileges or of medical staff membership.
      e. denial of requested clinical privileges except when the denial is based on the hospital's inability to provide clinical support necessary.
      f. imposition of monitoring or consultation requirement when agreement must first be reached with the monitor or consultant as to the course of treatment before treatment may be rendered; or,
      g. reduction, restriction, revocation or suspension of current clinical privileges.

C. Request for Hearing
   1. In all cases described in Section B of this Article, the affected member shall be promptly notified as provided in this Article of the adverse recommendation, the reasons for the recommended action, the right to request a hearing pursuant to this Section and the time within which to request a hearing, and given a summary of the member's rights during the hearing.
   2. The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Executive Committee or the Board of Trustees, as appropriate. If the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and appellate review to which he/she is entitled, and to have accepted the recommendation or action involved. Such action or recommendation shall then become effective against the member pending final action by the Governing Body. The Chief Executive Officer shall promptly notify the member of his/her status.
**D. Notice of Hearing**

1. Within fourteen (14) days after receiving a request for a hearing from a member, the Executive Committee or the Governing Body, whichever is appropriate, shall, through the Chief Executive Officer, notify the member of the time, place and date of the hearing. The hearing date shall be not less than thirty (30) days nor more than forty-five (45) days from the date of the notice to the member.

2. The notice of hearing shall state the acts or omissions with which form the basis of the proposed action, a list of specific or representation charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation, and shall contain a list of the witnesses who are expected to testify at the hearing on behalf of the recommendation.

3. The hearing may be postponed or extended by the member beyond the times provided in these Bylaws only with approval, and at the sole discretion, of the Hearing Committee upon a showing of good cause. The Hearing Committee may postpone the hearing beyond the time provided in these Bylaws for good cause shown with the concurrence of the member.

**E. Hearing Committee**

1. Upon receipt of a request for a hearing, the Chief of Staff, in consultation with the Chief Executive Officer, shall appoint a Hearing Committee. The Hearing Committee shall be composed of at least five (5) members, and alternates as appropriate, of the Active Medical Staff in good standing who are not on either the Executive Committee or the Board of Trustees. The Chief of Staff shall appoint one of the members as Chairperson. No committee member shall be in direct economic competition with the affected member, or have actively participated in considering the matter that is the subject of the hearing, unless the size of the active Medical Staff is too small, in which case, members of other categories may be selected. The Chief of Staff may at his/her discretion appoint additional members to the Hearing Committee as deemed necessary to attain a Peer Committee as to the specialty or privileges of the affected member.

**F. Conduct of Hearing**

1. The purpose of the Hearing is to determine the facts involved in the charge, to determine if the charge is supported by the evidence and to determine if the requested action is appropriate to the charge and based on the evidence.

2. There shall be at least three (3) members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.

3. An accurate record of the hearing must be kept. The Committee shall establish the mechanism, which may be a court reporter, electronic recording unit, detailed transcription.

4. A member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights to the hearing and to have accepted the adverse recommendation or proposed action involved. The recommendation or proposed action shall then become and remain effective against the member pending a final decision by the Governing Body.

5. The affected member shall be entitled to be accompanied and/or represented at the hearing by an attorney or another person of the member’s choice. The Executive Committee or Governing Body may appoint one of its members, some other Medical Staff member, or an attorney to represent it at the hearing.

6. The Chairperson of the Hearing Committee, or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and
documentary evidence, and to maintain decorum. The Chief Executive Officer may, in the alternative, appoint a hearing officer from within or outside the Facility, who is not in direct economic competition with the affected member, to serve as the presiding officer. The presiding officer may take such action as may be deemed necessary if he/she determines that either side is not proceeding efficiently and expeditiously. If a hearing officer is appointed by the Chief Executive Officer, such person shall not participate in the deliberations of the committee or vote.

7. The rules of law relating to the examination of witnesses or presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the admissibility of such evidence in a court of law. The Hearing Committee may at its discretion, order that oral evidence shall be taken only on oath or affirmation.

8. Within reasonable limits, both parties shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. Both parties shall also be entitled to submit a written statement on any issue of fact or procedure before, during or within ten (10) days after the hearing and such statement shall become part of the record. If the member does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

9. Except as provided in Section I of this Article, the Executive Committee or Governing Body, as appropriate, shall have the burden of presenting substantive evidence to support its recommendation or action. The affected member shall then have the burden of persuading the Hearing Committee to support his/her position.

10. The Hearing Committee may, without special notice, recess the hearing and reconvene it for the convenience of the participants or to obtain new or additional evidence. After presentation of all oral and written evidence, the hearing shall be closed. The Hearing Committee may then at a convenient time deliberate outside the presence of the affected member.

11. Within ten (10) days after closing the hearing, the Hearing Committee shall submit a written report and recommendation, including a statement of the basis for the recommendation, together with the hearing record and all other documentation, to the Executive Committee and to the Governing Body. A copy of the report and recommendation shall simultaneously be sent to the affected member. The report may recommend confirmation, modification, or rejection of the original adverse recommendation or proposed action. The Governing Body shall consider the Hearing Committee's report and recommendation, but shall not be bound by it.

12. The Governing Body shall take action on the Hearing Committee's report and issue a final decision and report with a statement of the basis for its decision within fifteen (15) days after receipt. Notice of this final decision, with a copy of the report, shall promptly be provided to the affected member by the Chief Executive Officer.

G. Appellate Review

1. Within fourteen (14) days after notice of the final action of the Governing Body, the affected member may, by written notice to the Governing Body, request an appellate review. The notice must state clearly and concisely the grounds for the appeal and the facts supporting it. If oral argument is desired, the notice must specifically request that it be permitted as part of the appellate review; otherwise, the appellate review shall be conducted only on the written record.

2. If the member does not request appellate review in the time and manner provided, he/she shall be deemed to have waived his/her right to appellate review, and to have accepted such final action which shall then become effective immediately.
3. The only grounds for appeal shall be:
   a. failure to comply substantively with these Bylaws;
   b. the recommendation or decision was arbitrary or capricious; or
   c. the recommendation or decision was not supported by substantial evidence.

4. Within fourteen (14) days after receipt of a request for appellate review, the Governing Body shall make a determination that the request is not in compliance with paragraph 3 or schedule a date for such review, including a time and place for oral argument if such has been requested, and shall notify the affected member in writing. The date of the appellate review shall not be more than thirty (30) days from the date of receipt of the request. The date of the appellate review may be postponed by the Governing Body upon a showing of good cause.

5. The appellate review shall be conducted by the Governing Body or by a duly appointed Appellate Review Committee of the Governing Body of not less than three (3) members. If the appellate review is of an initial proposed action of the Governing Body, the Appellate Review Committee will be an Ad Hoc Committee of three (3) Medical Staff members appointed by the Chief of Staff. The Ad Hoc Committee members shall be members in good standing of the Active Staff who are not in direct economic competition with the affected member and who have not participated in consideration of the matter during the process unless the size of the Medical Staff is too small, in which case, members of other categories may be selected. For the purposes of this Section, "Appellate Review Committee" shall mean the Governing Body or Appellate Review Committee or Appellate Ad Hoc Committee, as appropriate.

6. The affected member shall have access to the record (and transcript, if any) of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. He/she may be charged reasonable charges for copies of such material. This shall not include, however, minutes or proceedings of Peer Review committees or other records or information, which are confidential or privileged by law. Both parties to the appeal shall be permitted to submit a written statement in support of their position specifying the facts and procedures in dispute and the reasons therefore. A copy of the statement shall be provided to the other party when it is received by the Chief Executive Officer. This statement shall be submitted to the Appellate Review Committee at least ten (10) days before the date scheduled for the appellate review.

   New or additional evidence may be accepted by the Appellate Review Committee in its sole discretion and only if it can be shown that such information could not reasonably have been made available at the hearing. Both parties shall have the right to cross-examine concerning such additional or new information.

   If oral argument has been permitted, both parties shall be present at the Appellate Review to make oral arguments and answer questions addressed to them by the Appellate Review Committee. The time for oral argument and length of written statements may be limited by the Appellate Review Committee.

7. The Appellate Review Committee shall review the record created in the proceedings, and shall consider the written statements to determine whether:
   a. there was a substantial failure to comply substantively with the Medical Staff Bylaws; or
   b. the recommendation or decision was arbitrary or capricious; or
   c. the recommendation or decision was not supported by substantial evidence.

8. If the appellate review is conducted by the Governing Body, it may affirm, modify or reverse the prior decision, or in its discretion, refer the matter back to the Executive Committee for further review and recommendation within ten (10) days after the conclusion of the appellate review. If the matter is referred back to the Executive Committee, it may request that the Executive Committee arrange for a further
hearing to resolve specific disputed issues. The Executive Committee shall submit its report within thirty (30) days of such request.

9. If the review is conducted by the Appellate Review Committee of the Governing Body, it shall, within thirty (30) days of receipt of the request, either make a written report to the Governing Body recommending that the Governing Body affirm, modify or reverse the prior decision, or refer the matter back to the Executive Committee within ten (10) days for further review and recommendation. Such referral may include a request that the Executive Committee arrange for another hearing to resolve specific disputed issues. The Executive Committee’s report shall be due within ten (10) days after receiving the Executive Committee’s recommendation to the Governing Body.

10. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section have been completed or waived. Where permitted by the Board of Trustee Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

H. Final Decision by Governing Body

1. Within thirty-five (35) days after receiving the Appellate Review Committee’s recommendation, the Governing Body shall make its final decision in the matter and will send notice to the Executive Committee and to the affected member, as provided herein.

I. Right of Practitioner Applicants to Hearing

1. An applicant (non-member) to the Medical Staff, upon receiving notice of an adverse decision of the Governing Body on his/her application for membership or privileges, shall be entitled to a hearing in accordance with Article VIII, Paragraphs E and F of these Bylaws. The applicant shall request the hearing in writing within thirty (30) days of receipt of notice of the adverse decision. Failure of the applicant to request a hearing in the time and manner prescribed in this Article shall be deemed a waiver of the applicant’s rights to such proceedings and an acceptance of the Governing Body’s decision as final.

2. Within fourteen (14) days following receipt of a request for a hearing, the Governing Body shall, through the Chief Executive Officer, notify the applicant of the time, place and date of the hearing.

3. The Hearing Committee shall be constituted as described in Section E of this Article.

4. The Hearing Committee shall convene the hearing within not less than thirty (30) and not more than forty-five (45) days after giving notice to the applicant of the hearing. The hearing shall be conducted in the manner described in Section F of this Article. The Hearing Committee shall make a recommendation to the Governing Body within ten (10) days after closing the hearing. A copy of the recommendation shall be sent to the applicant. The applicant may also obtain a copy of the transcript of the hearing and may be charged reasonable charges for such copy.

5. If the Hearing Committee’s recommendation is still adverse to the applicant, the applicant may submit to the Governing Body a written statement containing the objections to the recommendation, including any allegations of procedural errors. The applicant may make an oral statement to the Governing Body as well.

6. The Governing Body shall consider the record of the hearing as well as the applicant’s written and/or oral statements in addition to all the other material presented with the application. The Governing Body shall determine whether:

   a. there was substantial failure to comply substantively with the Medical Staff Bylaws;
b. the initial decision was arbitrary or capricious;
c. the initial decision was supported by substantial evidence.

The Governing Body shall consider the recommendation of the Hearing Committee and shall render its final decision within thirty (30) days after receiving the recommendation.

7. The practitioner may waive his/her right to a hearing before the Hearing Committee and request a hearing before the Governing Body. The Governing Body’s decision will be final.

IX. Elected Officers

A. Officers of the Medical Staff

1. The officers of the Medical Staff shall be the:
   a. Chief of Staff (President of Staff);
   b. Chief of Staff-Elect (Vice Chief);
   c. Secretary-Treasurer;
   d. Two or more Representatives-at-Large;
   e. Immediate Past Chief of Staff.

B. Qualifications of Officers

1. Officers must be members of the Active Staff in good standing at the time of nomination and election and must remain in good standing during their term of office. Failure to maintain such status shall immediately terminate the officer’s term.

2. To qualify for the position of Chief of Staff or Chief of Staff-Elect, a Member of the Medical Staff must be a doctor of medicine or osteopathy. Medical staff members who are another type of practitioner may serve in other leadership roles, but not as Chief of Staff.

C. Nomination of Officers

1. The Nominating Committee shall prepare a list of one or more nominees for the offices of Chief of Staff – Elect; Secretary-Treasurer and Representatives-at-large.
2. The list of nominees shall be submitted to the Executive Committee for approval. If the Executive Committee disapproves of a nominee, the Nominating Committee shall be notified and a new nominee recommended. The Chairman of the Executive Committee shall publish the approved list of nominees to the Medical Staff at least fourteen (14) days before the annual meeting.

3. Nominations may also be made by petition signed by at least ten (10) members of the Active Staff with the written consent of the proposed nominee and filed with the Secretary-Treasurer of the Medical Staff at least seven (7) days before the annual meeting. No nominations shall be made from the floor at the annual meeting.

D. Election of Officers

1. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Staff present at the meeting shall be eligible to vote.

2. The official ballot shall specify which nominees are offered by petition. Voting shall be by secret ballot and officers shall be elected by majority vote. When there are three (3) or more nominees for an office and no candidate receives a majority on the ballot, the name of the nominee receiving the fewest votes will be omitted from each successive ballot until a majority vote is obtained for one nominee.

3. The Chief of Staff - Elect and three (3) other members of the Medical Staff named by the Chief shall serve as Tellers. The Tellers shall determine the procedure to be followed in counting the ballots.

4. Each elected officer is subject to, and shall take office only after, confirmation by the Governing Body. An elected officer may be removed from office by the Governing Body after notification to and consultation with the Executive Committee. If the Governing Body and the Executive Committee disagree as to whether such officer should not be confirmed or should be removed, such disagreement shall be resolved by a Joint Conference Committee pursuant to Section 111.E.1.

5. If there is no quorum at the annual meeting, the offices shall be considered vacant and shall be filled according to Section F of this Article.

6. The Chief of Staff - Elect shall become Chief of Staff upon the expiration or termination of the term of the preceding Chief of Staff.

E. Term of Office

1. Except as otherwise provided in these Bylaws, officers shall serve a two (2) year term beginning the first day of the new Medical Staff Year, or upon taking office, and ending on the last day of the Medical Staff Year immediately following assumption of office or until their successors take office (whichever occurs last), subject to the confirmation by the Governing Body. An officer must be out of office for one (1) year before being eligible to be nominated for another term in the same office. This does not preclude nomination of such officer to another office.

2. Officers of the Medical Staff may be recalled for grounds specified under Article VII, Section A (2), upon presentation to the Chief of Staff of a petition signed by thirty percent (30%) of the Active Staff members. Within twenty (20) days of receipt of a petition, the Chief of Staff shall verify the signatures and call a special meeting of the Medical Staff to vote on the recall. An officer shall be recalled and removed from office upon a vote of not less than two thirds of the Active Staff membership. The vote shall be by secret written ballot.
F. Vacancies in Office

1. Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled immediately by the Executive Committee, subject to confirmation by the Governing Body. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff - Elect shall serve out the remaining term after which the Chief of Staff - Elect shall be eligible to fulfill his/her full term as Chief of Staff. If there is no Chief of Staff - Elect, the Executive Committee shall fill the vacancy, subject to the approval of the Governing Body.

G. Duties

1. Chief of Staff - The Chief of Staff shall serve as chief administrative officer of the Medical Staff to:

   a. coordinate and cooperate with the Chief Executive Officer in enforcing Hospital policies and Bylaws and in all matters of mutual concern within the Hospital;
   b. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
   c. chair the Executive Committee and serve as a member of the Joint Conference Committee;
   d. serve as an Ex-Officio member of all other Medical Staff committees;
   e. be responsible for enforcing the Medical Staff Bylaws and Rules and Regulations, for implementing sanctions where they are indicated, and for the Medical Staff complying with the procedural safeguards in all disciplinary proceedings;
   f. appoint committee chairmen and members to all standing and special committees of the Medical Staff except as provided in these Bylaws;
   g. represent the views, policies, needs and grievances of the Medical Staff to the Governing Body, the Chief Executive Officer and the corporation;
   h. receive and implement the policies of the Governing Body and report to the Governing Body on the effectiveness of the Quality Assurance program, the clinical performance and quality patient care of the Medical Staff related to its delegated responsibility to provide quality patient care;
   i. be responsible for the continuing education activities of the Medical Staff; and
   j. represent the Medical Staff in its external professional and public relations.

2. Chief of Staff - Elect - In the absence of the Chief of Staff, he/she shall assume the duties and the authority of the Chief. He/she shall be a member of the Executive Committee and the Chairman of the Credentials Committee. He/she shall automatically succeed the Chief when the latter fails to serve for any reason.

3. Secretary-Treasurer - He/she shall be a member of the Executive Committee. The Secretary-Treasurer shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings pursuant to these Bylaws, attend to all the correspondence and perform such other duties as ordinarily pertain to his/her office. He/she shall also act as the Treasurer and as such he/she shall collect, disburse and be accountable for all Medical Staff funds, dues, etc. He/she shall render a monthly financial report to the Executive Committee and provide a financial statement at the Staff meetings.

4. Immediate Past Chief of Staff - The Immediate Past Chief of Staff shall be a member of the Executive Committee and the Nominating Committee and shall perform such other advisory duties as are assigned to him/her by the Chief of Staff, Executive Committee or the Governing Body.

5. Representatives-at-Large - The Representatives-at-Large shall be members of the Executive Committee. They shall also perform such duties as are assigned to them by the Chief of Staff.
X. Meetings

A. The Annual Meeting

1. The annual meeting of the Medical Staff shall be the last quarterly meeting before the end of the Medical Staff election year. At this meeting, the Nominating Committee shall present the slate of nominees for officers. Officers for the ensuing term shall be elected and installed. This meeting shall include a business session in which all departments (and sections thereof) and committees shall be required to present an annual report. If Staff funds exist, a report of the auditors shall be presented.

B. General Meetings

1. Regular meetings of the Medical Staff shall be held not less than quarterly at a time and place designated by the Executive Committee.

C. Special Meetings

1. Special meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of the Governing body, the Executive Committee, or by the joint written request of at least twenty-five percent (25%) of the Active Staff. At any special meeting no business shall be transacted except that stated in the notice of the meeting.

D. Attendance at Meetings

1. All members of the Medical Staff are encouraged to attend relevant Department (or Section) and General Medical Staff meetings, but are not required to do so, unless otherwise determined by policy of the Medical Executive Committee or by the Medical Staff Department.

E. Quorum

1. Voting members present at such meeting shall constitute a quorum. (Voting members are: Active)

F. Manner of Action

1. The action of a majority of members present and voting at a meeting at which a quorum is present shall be the action of the Medical Staff. Only members who have attended at least 50% of the Medical Staff meetings during the twelve months preceding the meeting in question shall have the right to vote at such meeting.

G. Clinical Presentations

1. If a case is to be discussed at a meeting because of problems found either during routine case review, or otherwise, the affected member shall be notified and shall be present when the case is discussed. The member shall not unreasonably refuse to attend. The case shall be presented in the member’s absence unless the absence is excused and the member has requested that discussion be postponed. Discussion shall not be postponed later than the next regular meeting.

H. Order of Business and Agenda

1. The meeting shall be conducted according to Roberts’ Rules of Order as last amended. The agenda shall include at least:
a. reading and acceptance of the minutes of the last regular meeting and of all special meetings held since the last regular meeting;
b. administrative reports from the Chief Executive Officer, the Chief of Staff, department chairmen, and committee chairmen;
c. The election of officers, when required by these Bylaws;
d. reports by responsible officers, committees, and departments on the overall results of patient care audits and other quality assurance activities of the Staff and on the fulfillment of any required Staff functions;
e. recommendations for improving patient care within the Hospital.

2. The agenda at special meetings shall be:
   a. reading of the notice calling the meeting; and
   b. transaction of the business for which the meeting was called.

I. Minutes

1. Minutes of all meetings shall be prepared by the Secretary-Treasurer and shall include a record of attendance and the vote taken on each matter. The minutes shall be signed by the Chief of Staff and copies shall be made available to the Staff. The Chief Executive Officer shall maintain a permanent file of the minutes of each meeting.

J. Meeting as a Committee-of-the-Whole

1. Notwithstanding any other provision of these Bylaws, whenever the medical staff or a department or service meets, it shall be considered to be meeting as a committee of the whole medical staff, department, or service, respectively.

K. Confidentiality

1. All meetings shall be open to any member of the Medical Staff. Meeting Chairmen may close a portion of any meeting if in their judgment the best interest of the medical staff is served by this closure.

XI. Departments and Sections of the Medical Staff

A. Departments

1. The departments and sections of the staff shall be as follows:
   a. Department of Medicine
      1) Section of Internal Medicine (to include the following which may be designated as separate sections): Gastroenterology; Family Medicine; Nephrology; Endocrinology; Allergy; Dermatology; Hematology and Oncology.
      2) Section of Pulmonary Medicine.
      3) Section of Neurology.
      4) Section of Psychiatry.
      5) Section of General Practice/Family Practice
      6) Section of Hospitalists
   b. Department of Surgery
      1) Section of General Surgery (to include the following which are not designated as separate sections): Proctology, Neoplastic and Traumatic Surgery.
      2) Section of Neurosurgery.
      3) Section of Urology.
      4) Section of Plastic Surgery (to include Facial Plastic Surgery).
      5) Section of Ophthalmology.
6) Section of Otorhinolaryngology (to include Facial Plastic Surgery).
7) Section of Oral Surgery and General Dentistry.
8) Section of Orthopedics
9) Section of Vascular (MEC 4/06)
c. Department of Anesthesiology.
d. Department of Diagnostic Imaging.
e. Department of Emergency Medicine.
f. Department of Pathology.
g. Department of Pediatrics.
h. Department of Obstetrics and Gynecology.
i. Department of Cardiovascular Medicine and Cardiac Surgery.

2. Other departments or sections may be established from time to time upon the written request to the Executive Committee by the membership of the Active staff or a department and upon approval of the Executive Committee and Governing Body. No department or section may be established or maintained with less than three (3) Active staff members, except Hospital-based departments.

3. An approved and authorized department or section may be eliminated if the Executive Committee and Governing Body determine that the patient activity of the department or section has decreased so that it is not substantial enough to warrant such status or the number of Active staff members decreases to less than three (3), except Hospital-based departments.

B. Organization of Departments

1. Each department shall be organized as a separate part of the Medical Staff and shall have a chairman who is appointed and has the authority, duties and responsibilities as specified in this Article.

2. In order to promote and maintain quality care, lower costs and administrative efficiency, Hospital-based services may be provided through physician contracts with the Hospital. Such agreement(s) may provide for the extent of such services. The Medical Director shall be approved, as any other member, for membership and privileges except as otherwise provided in these Bylaws. The Governing Board or Chief Executive Officer shall reasonably consult with the Executive Committee prior to entering into additional contracts pertaining to different services if the purpose of such contract would be to grant the exclusive right to perform such services to a particular person or group.

C. Assignment to Departments

1. Each member of the Staff shall be assigned to not more than one (1) department but may be granted clinical privileges in one (1) or more department. The exercise of clinical privileges within any department shall be subject to the rules and regulations of that department and the authority of the Department Chairman.

2. Advanced Practice Professionals (APP)s, regardless of source of employment and degree of practice independence, shall be assigned to a department where their clinical performance shall be monitored. They shall be subject to all applicable rules and regulations of the department and authority of the Department Chairman.

D. Functions of Departments

1. The primary responsibility of each department is to implement and conduct specific monitoring review and evaluation activities that contribute to preserve and improve the quality and efficiency of patient care provided in the Hospital.

2. To carry out this responsibility, each department shall:
a. Conduct ongoing monitoring to analyze, review and evaluate the quality and efficiency of care within the department based on objective criteria reflecting current knowledge and clinical experience. This function shall be designed to strive to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served: (i) the ability to obtain information and interpret information in terms of the patients’ needs; (ii) a knowledge of growth and development; and (iii) an understanding of the range of treatment needed by these patients. Each department shall review all clinical work performed under its jurisdiction whether or not the practitioner is a member of the Department. The Department shall also identify actions to be taken to resolve identified problems.

b. Establish criteria for granting clinical privileges in the department and submit the recommendations required under these Bylaws regarding the specific privileges to be granted to each Staff member or applicant and each health professional affiliate.

c. Conduct or participate in, and recommend continuing education programs pertinent to changes in the state-of-the-art and to findings of review and evaluation activities.

d. Monitor on a continuing and concurrent basis, adherence to:

   (1) Staff Bylaws, Rules and Regulations, and Hospital policies and procedures;
   (2) requirements for alternate coverage and consultations;
   (3) sound principles of clinical practice; and
   (4) fire and other regulations designed to promote patient safety.

e. Coordinate the patient care provided by the department's members with nursing and ancillary services and administrative support services.

f. Foster an atmosphere of professional decorum within the department appropriate to the healing arts.

g. Submit reports to the Executive Committee on a regularly scheduled basis concerning:

   (1) findings of the department's review and evaluation activities, action taken thereon and the results of such action;
   (2) care provided in the department and the Hospital; and
   (3) such other matters as may be requested from time to time by the Executive Committee.

h. Meet at least four times per year to receive, review and consider patient care review findings and the results of the department's other monitoring, evaluation and education activities and to perform or receive reports on other department and staff functions.

i. Establish such committee or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

j. At the discretion of each department chairman, each department shall establish written rules and regulations for the organization, operation and function of the department that do not conflict with the Medical Staff Bylaws and Rules and Regulations. If established, the Rules and Regulations must be reviewed annually and any additions, deletions, revisions or changes must be approved by the Executive Committee and ratified by the Governing Body.
E. Organization of Sections

1. Each approved and authorized specialty subdivision within a department shall be directly responsible to the department within which it functions, and shall have a chairman who is appointed and has the authority, duty and responsibility as specified in this Article.

F. Function of Sections

1. Each approved and authorized section shall perform the functions assigned to it by the Department Chairman. Such functions may include, without limitation: the continuous monitoring of patient care practices; continuing medical education programs; credentials review and privileges delineation. The section shall transmit regular reports to the Department Chairman on the conduct of its assigned functions.

G. Qualifications, Appointment and Tenure of Department Chairman

1. Each Department shall have a chairman who shall be a member in good standing of the Active Staff and the department, shall be certified by a specialty board relevant to the services provided by the department or shall demonstrate through the privilege delineation process comparable competence to an individual with board certification, shall be qualified by training, experience, interest and demonstrated current ability in the clinical area covered by the department, and shall be willing and able to discharge the administrative responsibilities and functions of the office.

2. Each clinical Department Chairman, except as otherwise provided in these Bylaws, shall be elected subject to approval of the Executive Committee. Each Hospital-based Department Chairman shall be appointed by the Governing Body after reasonable consultation with the Chief of Staff.

3. Each Department Chairman, except as otherwise provided in these Bylaws, shall serve a two (2) year term commencing on the first day of the new Medical Staff year. He/she shall serve until the end of the succeeding Medical Staff Year or until his/her successor takes office, whichever is later. A Department Chairman shall be eligible to succeed himself. A Department Chairman shall be removed from office by the Chief of Staff, upon the recommendation of the Executive Committee, or by two-thirds (2/3) majority vote of the Department members eligible to vote.

4. Each Department shall elect a Vice Chairman who must be approved by the Executive Committee. The Vice Chairman shall assume the duties and authority of the Chairman in his/her absence and be responsible for such duties as may be assigned by the chairman. The Vice Chairman shall serve the same term as the Chairman and may be removed in the same manner as the Chairman or by the Chairman.

5. Each Department Chairman and Vice Chairman is subject to, and shall take office only after, confirmation by the Governing Body. A Department Chairman or Vice Chairman may be removed from office by the Governing Body after notification to and consultation with the Executive Committee. If the Governing Body and the Executive Committee disagree as to whether such Department Chairman or Vice Chairman should not be confirmed or should be removed, such disagreement shall be resolved by a Joint Conference Committee pursuant to Section 111.E.1.

H. Duties of Department Chairman

1. The duties of the Department Chairman shall be to account to the Executive Committee for all professional and administrative activities within his/her department and particularly for the quality of patient care rendered by members of the department and the effective conduct of the performance evaluation, other quality improvement functions delegated in the department, and the maintenance of Quality Control programs;
2. develop and implement departmental programs to review credentials and delineate privileges, continuing medical education, utilization review, provide for planned, systematic ongoing monitoring of appropriateness of care and other quality improvement functions as required by these Bylaws;

3. serve on the Executive Committee, give guidance on the overall development and implementation of policies and procedures that guide and support the provision of services of the Hospital, and make specific recommendations and suggestions regarding his own department;

4. continuously review the professional performance of all practitioners and health professional affiliates with clinical privileges in the department and report monthly thereon to the Executive Committee;

5. transmit the department's recommendations concerning appointment and Staff category, reappointment, delineation of clinical privileges or specific services, and disciplinary action with respect to practitioners in the department;

6. appoint such committees as are necessary to conduct the functions of the department and designate a chairman and secretary for each;

7. enforce the Hospital and Medical Staff Bylaws and Rules and Regulations; policies, and department rules and regulations including initiating disciplinary action and investigation of clinical performance and ordering consultations;

8. implement Executive Committee actions in the department;

9. participate in every phase of department administration with the nursing service and the Hospital administration in matters affecting patient care including making recommendations for sufficient number of qualified and competent persons, space and other resources needed by the department to provide care or service; and special regulations, standing orders, and techniques, including assigning physicians for appropriate Emergency Room on-call coverage.

10. recommend the criteria for clinical privileges that are relevant to the care provided in the department;

11. assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization;

12. integration of the department or service into the primary functions of the organization and the coordination and integration of interdepartmental and intradepartmental services;

13. the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services;

14. orientation and continuing education of all persons in the department or service;

15. assist in the preparation of annual reports, including budget planning, pertaining to the department as may be required by the Executive Committee, the Chief Executive Officer, or the Governing Body; and,

16. perform such other duties as may from time to time be reasonably requested by the Chief of Staff, the Executive Committee, the Chief Executive Officer or the Governing Body.
I. Qualifications, Appointment Tenure, and Duties of Section Chairman

1. Each Section Chairman shall be:
   a. a member in good standing of the Active Staff and of the applicable section, and
   b. be qualified by training, experience, interest and demonstrated current capability in the clinical area covered by the section, and
   c. willing and able to discharge the administrative responsibilities of the office.

2. Each Section Chairman shall be appointed by the Department Chairman with the approval of the Executive Committee. A Section Chairman may be removed from office in the same manner as a Department Chairman.

3. Each Section Chairman shall serve a two (2) year term, concurrent with the Medical Staff Year and until his/her successor takes office. A Section Chairman shall be eligible to succeed himself/herself.

4. Each Section Chairman shall perform such duties as may be assigned by the Department Chairman and such other duties commensurate with his office as may from time to time be reasonably requested by the Department Chairman, the Executive Committee, the Chief Executive Officer or the Governing Body.

5. Each Section Chairman is subject to, and shall take office only after, confirmation by the Governing Body. A Section Chairman may be removed from office by the Governing Body after notification to and consultation with the Executive Committee. If the Governing Body and the Executive Committee disagree as to whether such Section Chairman should not be confirmed or should be removed, such disagreement shall be resolved by a Joint Conference Committee pursuant to Section 111.E.1.

XII. Department Meetings

A. Regular Meetings

1. A regular meeting of each department (and section if prescribed by the Department Chairman) shall be held at least quarterly to review and evaluate the clinical work of practitioners and affiliates with privileges in the department. The meeting shall include at least the following:
   a. A thorough review of work done in the department with emphasis on utilization review, quality assurance, risk management and morbidity and mortality analysis with detailed consideration of selected deaths, unimproved cases, infections, complications or errors in diagnosis and results of treatment. This review shall include medical record number and date of admission of the cases discussed with written resume and/or synopsis of each including recommendations, conclusions and actions of the department.

B. Special Meetings

1. The Department Chairman may call special meetings or convene special department committees as he/she deems necessary to accomplish the purposes of the department.

C. Quorum

1. Voting members present at such meetings shall constitute a quorum (voting members are: Active).
D. Minutes

1. Minutes of each department or section meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be reviewed, approved, and signed by the presiding officer. The permanent file for all department (and section) meetings shall be maintained in the Chief Executive Officer’s office.

E. Manner of Action

1. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of that department (or section).

F. Attendance Requirements

1. All members of the Medical Staff are encouraged to attend relevant Department (or Section) and General Medical Staff meetings, but are not required to do so, unless otherwise determined by Policy of the Medical Executive Committee or by the Medical Staff Department.

2. A member of the Medical Staff whose patient’s clinical case is scheduled for discussion at a department (or section) meeting shall be so notified and shall be expected to attend such meeting. If the member is not otherwise required to attend the department (or section) meetings, the Chief of Staff shall, through the Chief Executive Officer, give the member advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the member shall so state, shall be given by certified mail, return receipt requested, and shall include a statement that attendance at the meeting is mandatory.

3. Failure of a member to attend any meeting of which he/she was given notice of mandatory attendance or who fails to comply promptly with appropriate requests of duly constituted committees for cooperation and assistance, including but not limited to letters from duly constituted committees or departments, unless excused by the Chief of Staff or department (or section) head upon a showing of good cause, may be cause for disciplinary action. In all cases, if the member shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the chairman until not later than the next regular meeting. Otherwise the pertinent clinical information shall be presented and discussed as scheduled.

XIII. Committees

The committees of the Medical staff shall consist of Standing Committees and Special Committees, the latter appointed on an ad hoc basis. The Standing Committees of the Medical Staff shall be as follows: Executive; Credentials; Nominating; Quality Council; Utilization Review; Bylaws, SSD Steering Committee; Medical Records; Patient Safety, Pharmacy and Therapeutics; Infection Control; Acute Care; Radiation Safety; Blood Utilization Review; Ethics; and CME.

The Chief of Staff and/or the Chief of Staff-Elect and the Chief Executive Officer or his/her designee shall be ex-officio members of all committees unless otherwise designated.

The Chief of Staff shall, after consultation with the Executive Committee and approval by the Governing Body, appoint members to all standing committees except the Executive Committee unless otherwise provided in these Bylaws.

Minutes of all committee meetings shall be transcribed and maintained in the Office of the Chief Executive Officer.
Executive Committee

1. Composition - The Executive Committee shall consist of the following members: the chairman of each clinical department; the officers of the Medical Staff, including two (2) Representatives-at-Large; the Chairmen of Diagnostic Imaging, Pathology, Anesthesiology and Emergency Medicine. The Chief of Staff shall serve as Chairman. The Chief Medical Officer shall serve as an ex-officio member.

Chief Medical Officer

The Chief Medical Officer shall be a physician who is employed or under contract with the Hospital to perform administrative duties related to the medical staff affairs of the Hospital. The Chief Medical Officer is not elected by the Medical Staff and therefore is not one of the officers of the Medical Staff organization.

QUALIFICATIONS

The Chief Medical Officer shall possess all of the qualifications for Medical Staff membership if the Chief Medical Officer desires Medical Staff membership or clinical privileges to provide patient care services.

RESPONSIBILITIES AND AUTHORITY

The Chief Medical Officer shall serve as an advisor to the officers of the Medical Staff and as a liaison between the Medical Staff and the Administration of the Hospital. The authority of the Chief Medical Officer shall be that of an administrator of the Hospital, as assigned by the Chief Executive Officer. Specific responsibilities include, but are not limited to:

a) Administratively oversee the Medical Staff Office in performance of the credentialing function;

b) Serve as a designee of the Chief Executive Officer in reviewing and approving applications for temporary privileges;

c) Serve as an ex-officio member of all Medical Staff committees, without vote;

d) Advise and assist the officers of the Medical Staff in the performance of their duties, including providing orientation and education to Medical Staff leaders with regard to their leadership roles.

APPOINTMENT

After having received input from the Medical Executive Committee, Chief Medical Officer shall be appointed by the Chief Executive Officer and approved by the Board.

VACANCY

In the event of a vacancy in the position of Chief Medical Officer, the Chief of Staff shall ensure that any Medical Staff functions associated with the position are performed.

2. Duties - The duties of the Executive Committee shall be:

a. To represent, respond to and act on behalf of the Medical Staff subject to any limitations imposed by these Bylaws.
b. To manage the affairs and organization of the Medical Staff, and to enforce rules, regulations, and policies.

c. To coordinate the activities and general policies of the services, committees and/or departments as required.

d. Request evaluations of practitioners privileged through the medical staff process where there is doubt about an applicant's ability to perform the privileges requested;

e. Evaluate individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities;

f. Communicate to the appropriate parties the findings, conclusions, recommendations and actions taken to improve practitioner performance and implementation of changes to improve performance.

g. To receive, review, evaluate and act upon reports of the Medical Staff departments and committees, and to act for the Medical Staff in the intervals between Medical Staff meetings.

h. To review the recommendations of the Credentials Committee regarding applicants for appointment, reappointment, advancement or changes in Staff category, delineation of clinical privileges and/or assignments to services and make recommendations to the Governing Body and Corporation.

i. To implement policies of the Medical Staff.

j. To take all reasonable steps to ensure professional and ethical conduct by all members of the Medical Staff and to initiate and/or participate in Medical Staff disciplinary action or reviews as indicated.

k. To serve as liaison among the Medical Staff, the Chief Executive Officer, the Governing Body and the Corporation.

l. To recommend action to the Chief Executive Officer on medico-administrative matters.

m. To make recommendations to the Governing Body through the Chief Executive Officer with regard to:
   - the structure of the medical staff,
   - the mechanism by which medical staff membership may be terminated,
   - the mechanism for fair-hearing procedures,
   - the mechanism to review credentials and to delineate individual clinical privileges,
   - the participation of the Medical Staff in organization process improvement activities, and
   - Hospital management matters, such as long-range planning.

n. To fulfill the Medical Staff's accountability to the Governing Body for the quality of the medical care rendered to the patients in the Hospital.

o. To ensure that the Medical Staff is kept informed of the accreditation program and status of the Hospital.

p. To prepare the programs of all meetings, either directly or through a program committee or other suitable agent.

q. To report at each regular and annual Medical Staff meeting.
3. Meetings - The Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.

B. Credentials Committee

1. Composition - The Credentials Committee shall consist of one (1) Active Staff member from each of the clinical departments, one (1) Active Staff member who will represent all of the Hospital-based specialty departments and two (2) Representatives-at-Large selected from the Active Staff. The Chief of Staff-Elect of the Medical Staff shall serve as Chairman.

2. Duties - The duties of the Credentials Committee shall be:

a. To review the report and recommendations of the Department Chairmen regarding all applicants for membership to the staff to ensure that all investigations were pursued with total objectivity, fairness, and impartiality and that the recommendations are soundly based and compatible with the established criteria, needs and objectives of the Medical Staff and Hospital.

b. To make a report and recommendations to the Executive Committee of the Medical Staff regarding each applicant for Staff membership in conformity with Article IV of these Bylaws.

c. To review the report and recommendations of the Department Chairmen regarding the competence of Staff members and, as a result of such review, to make a report and recommendations to the Executive Committee of the Medical Staff regarding clinical privileges to be granted, reappointments, the assignment of members to the various sections and departments, and changes or advancements in Staff category as provided for in these Bylaws.

d. To investigate any breach of ethics that may be reported by the Executive Committee, Tissue and Transfusion Committee or Infectious Disease Committee and to transmit its findings and recommendations to the Executive Committee.

3. Meetings - The Credentials Committee shall meet at least once a month, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee of the Medical Staff.

C. Nominating Committee

1. Composition - The Committee shall consist of the Chief of the Medical Staff, the Vice Chief and four (4) members of the Active Staff appointed by the Chief of Staff.

2. Duties - The Committee shall prepare and recommend a slate of nominees for the offices of the Chief of Staff, Chief of Staff-Elect, Secretary-Treasurer and two (2) or more Representatives-at-Large.

3. Meetings - The Nominating Committee shall meet bi-annually, at least sixty (60) days before the annual meeting, maintain a permanent record of its proceedings and actions, and report its recommendations to the Chief Executive Officer and the Executive Committee.

D. Patient Safety Committee

1. Composition: Chief Executive Officer or Chief Operating Officer, Chief Nursing Officer, Associate Administrator, Quality Management Director, Risk Management Director, Physician Advisor for Patient Safety, Infection Control Coordinator, Utilization Management Director, Education Manager, Clinical Pharmacist, a designated community representative and selected representatives from the nursing staff.
2. **Duties** - The duties of the Patient Safety Committee shall be:
   a. To oversee the hospital-wide patient safety program to ensure that the program is effective, implemented throughout the organization and is integrated with other activities in the organization that contribute to the maintenance and improvement of patient safety.
   b. To maintain a written Patient Safety Plan for adoption by the Medical Executive Committee and the Board of Directors.
   c. To reduce the risk of medical errors and hazardous conditions by creating a culture of safety.
   d. To encourage medical error identification and reporting by all staff.
   e. To ensure staff is knowledgeable about patient safety policies and procedures.

3. **Meetings** - The Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Medical Executive Committee.

**E. Quality Council**

1. **Composition** - Chief Executive Officer or Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Quality Management Director, Risk Manager, Human Resources Director, Chiefs of the Medical Staff or designee, Managers of Laboratory, Diagnostic Imaging, Pharmacy, Respiratory Care Services and Cardiovascular Services. The Chief of the Medical Staff or designee who is a member of the active medical staff shall serve as Chairman.

2. **Duties** - The duties of the Quality Council shall be:
   a. Oversight of the hospital-wide quality improvement program to assure that the program is process oriented, multidisciplinary, coordinated, integrated, and effective.
   b. Evaluation and prioritization of program activity and focus.
   c. Approval of QAT formation.
   d. To maintain a written Continuous Quality Improvement Plan for adoption by the Executive Committee and the Governing body and to evaluate the continuous quality improvement program annually.
   e. To continually assess and provide for the educational needs of the hospital and medical staff with regards to the implementation and growth of the continuous quality improvement program.

3. **Meetings** - The Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee.

**F. Utilization Review**

1. **Composition** - The Utilization Review Committee shall consist of not fewer than three (3) nor more than ten (10) members of the Medical Staff who broadly represent the services of the Medical Staff. No member will have a direct or indirect financial interest in the Hospital. The Director of Nursing Services or designee, Medical Records and Social Services will be ex-officio members.

2. **Duties** - The duties of the Utilization Review Committee shall be:
   a. To develop, maintain and execute an effective Utilization Review Plan and to strive to assure that the functions required by the Plan are continuously performed and documented in a proper and timely manner.
b. To effect the efficient utilization of beds and services through concurrent and retrospective reviews of the necessity for inpatient admissions, appropriate duration of stays and the timely and appropriate use of diagnostic and therapeutic facilities.

c. To develop a plan whereby the patient receives no more nor less care than he/she needs and to assure the purchaser of this care that the care purchased is medically necessary, delivered in the most economical way by using the least expensive facilities and services available that will assure the quality of care in conformity with criteria of optimal use as determined by the physician's peers.

d. To develop, maintain and execute the functional elements of the Professional Review Organization Program, namely, admissions request, pre-admissions testing, admission certification, length of stay review, discharge planning and retrospective evaluation of performance measured against clinically valid criteria.

3. Meetings - The Committee shall meet at least quarterly, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee and the Quality Council.

G. SSD Steering Committee

1. Composition - The SSD Steering Committee shall consist of at least five (5) members of the surgical specialties, to include the Chairman of the Department of Surgery, one (1) anesthesiologist, and the Perioperative Nurse Manager. The Chairman of the Department of Surgery shall serve as Chairman of this committee.

2. Duties - The duties of the SSD Steering Committee shall be:

   a. To act as liaison between the Medical Staff and the Administration in matters pertaining to the Surgical Suite.

   b. To assist in the formulation and maintenance of the highest standards of surgical care in the Operating Room, PACU, and Day Surgery.

3. Meetings

   a. The SSD Steering Committee shall meet at least four (4) times a year, and more often if deemed necessary by the Chairman.

   b. The Committee will maintain a permanent record of its findings and recommendations to the Executive Committee of the Medical Staff.

H. Medical Records Committee

1. Composition - The Medical Records Committee shall consist of representation of the Medical Staff, representatives from Administration, and Nursing Services and the Director of Medical Records.

2. Duties - The duties of the Medical Records Committee shall be:

   a. To provide that all medical records meet the high standards of patient care usefulness, historical validity and realistic documentation of medical events. To conduct a quarterly examination, review and evaluation of currently maintained medical records to ensure that they properly describe and accurately reflect the condition and progress of the patient and therapy provided, the results thereof, and the responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criterion of medical comprehension of the case in the event of transfer of physician...
responsibility for patient care. To conduct on a continuous basis a review of records of discharged patients to measure their adequacy as a source document and compare their content with established standards of promptness, completeness.

b. To recommend any changes in the format of the medical records and to advise the Director of Medical Records concerning filing, indexing, storage, and availability of medical records.

c. To assist the Director of Medical Records in maintaining complete medical records and to monitor the delinquency of medical records and timeliness of completion and to recommend to the Chief Executive Officer and Chief of Staff that practitioners considered delinquent be suspended from admitting privileges in the Hospital until such charts are brought up to date.

3. Meetings - The Committee shall meet at least quarterly, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee and to the Chief Executive Officer.

I. Blood Utilization Evaluation Committee

1. Composition - This Committee shall consist of at least four to six members of the Medical Staff to include a clinical pathologist, a hematologist.

2. Duties - The duties of the Committee shall be:

   a. To evaluate clinical practice objectively for compliance with the criteria for the use of whole blood and each of its components administered in the Hospital.

   b. To evaluate untoward transfusion reactions. In addition, the committee shall strive to assure the adequate reporting of actual or suspected transfusion reactions, including the recommendation of periodic inservice training for nursing personnel in order to identify all such reactions.

   c. To maintain and evaluate blood use statistics in order to determine blood wastage and recommend or take appropriate action.

   d. To encourage strongly the increased use of the type and screen vs. type and crossmatch procedure.

   e. To evaluate physician and procedure profiles to identify patterns of isolated instances of blood use that require more in depth evaluation or obvious corrective action.

3. Meetings - The Committee shall meet as often as required, but not less than quarterly.

J. Pharmacy and Therapeutics Committee

1. Composition - The Committee shall consist of members from each medical department, and representatives of Administration, Pharmacy and Nursing Services.

2. Duties - The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital to achieve optimum clinical results and a minimum potential for hazard. Specifically, the committee’s duties shall be:

   a. To assist in formulating broad professional policies regarding the drug evaluation, selection, procurement, distribution, use, safety procedures, evaluation of reported drug reactions, determine who may administer drugs, and other matters relating to drugs in the Hospital.
b. To advise the Medical Staff and Administration on matters pertaining to the choice of drugs.

c. To add to and delete from the list of drugs accepted for use in the Hospital.

d. To prevent unnecessary duplication in the stock of the same basic drug and its preparation.

e. To make recommendations concerning drugs to be stocked in the nursing units and by other services.

f. To evaluate clinical data concerning new drugs or preparations requested for Hospital.

g. To develop a Hospital formulary or drug list of accepted drugs for use in the Hospital and to evaluate the appropriate use of high risk drugs, including antibiotics.

h. To review untoward drug reactions and medication errors.

i. To perform drug use reviews and antibiotic reviews.

j. To review the use of any investigational drugs.

3. Meetings - The Committee shall meet at least six (6) times a year, and more often if deemed necessary by the Chairman, maintain a permanent record of its proceedings and action and report its finding and recommendations to the Executive Committee.

K. Infection Control Committee

1. Composition - The Committee shall consist of at least four (4) members of the Medical Staff, a pathologist, and representatives from Administration, Nursing Services and Laboratory. When a quorum is not present, business may be conducted with a minimum of one physician present with minutes forwarded to Executive Committee for final approval.

2. Duties - The Committee shall be responsible for the surveillance of inadvertent infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards and the supervision of infection and environmental sanitation control in all phases of the Hospital's activities. Specifically, the Committee's duties shall be:

a. To develop written standards for Hospital sanitation and medical asepsis to include a definition of infection for the purpose of surveillance, as well as specific indications of the need for and the procedures to be used in isolation. Copies of the standards should be distributed and made readily available to all appropriate personnel.

b. To develop, evaluate and revise on a continuing basis the procedures and techniques for meeting established sanitation and aseptic standards to include the routine evaluation of materials used in the Hospital's sanitation program, namely: dietary and food handling, disposal of biological wastes, traffic control and visiting hours in all areas, sources of pollution and routine periodic culturing of autoclaves and gas sterilizers. The review of existing practices should also include procedures for the education and orientation of personnel in the practice of aseptic techniques. The evaluation may be based upon data supplied from reputable sources or upon in-use tests performed within the Hospital.
c. To develop a practical system for reporting, evaluating and recording infections among patients and personnel in order to provide an indication of endemic situations.

d. To assist in developing the Hospital's employee health program.

e. The Chairman of this committee shall have authority temporarily to institute appropriate control measures or studies when there is reasonably considered to be an immediate danger to any patient or personnel.

3. Meetings - The Committee shall meet at least six (6) times per year and more often if deemed necessary by the Chairman, and review data obtained since the previous meeting. Such review may include: reports of Hospital-associated infections including identification of patients requiring isolation; reports of tests conducted on sterilization devices; and reports of bacteriological studies of personnel, patients and the environment. An accurate record and minutes shall be kept of the committee's proceedings and actions and a report of its findings and recommendations shall be made to the Executive Committee and the Chief Executive Officer.

L. Acute Care Committee

1. Composition - The committee shall consist of three (3) members of the Department of Medicine including one (1) cardiologist and one (1) pulmonologist, the Emergency Medicine Department Chairman, and may have additional three (3) members of the Active Medical Staff. Ex-officio members shall be the Critical Care Units Nurse Manager, the Director of Nursing or designee, the Cardiopulmonary Department Manager and an Administration representative.

2. Duties - The duties of the committee shall be:

   a. To evaluate and maintain quality patient care in the unit; to see that safety standards are maintained; and to see that training and education of nursing staff and practitioners is maintained on a continuing basis.

   b. To seek ways and means for improving the professional standards and functions of these services for better patient care and proficiency in the execution of the detailed responsibilities.

   c. To be responsible for formulating and assuring compliance with the established rules and regulations of the Special Care Unit and for the maintenance of the highest professional conduct of the Medical Staff using these facilities.

   d. To receive and consider all recommendations made by members of the Medical Staff for improving the efficiency of these units.

3. Meetings - The Committee shall meet at least quarterly, and more often if deemed necessary by the Chairman, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee.

M. Radiation Safety Committee

1. Composition - The Committee shall consist of these four (4) individuals: 1) an authorized user of each type (of radioisotope) permitted by the license (the Radiation Safety Officer can also serve as an authorized user); 2) a representative of Nursing; 3) a representative of management; and 4) an individual who is experienced in the assay of radioactive materials. The committee may also include one (1) representative of the Medical Department and the Surgery Department.

2. Duties - The duties of the Committee shall be:

   a. To review all proposals for diagnostic and therapeutic use of radionuclides.

   b. To recommend to the Medical Staff practitioners who have suitable training and experience to perform nuclear medicine procedures.
c. To develop policy and procedures for the use, removal, handling and storage of radioactive materials used in nuclear medicine procedures and to recommend remedial action when there is failure to observe such regulations.

d. To oversee the radiation safety program, maintain occupational doses as low as reasonably can be expected, and review the program annually.

3. Meetings - The Committee shall meet at least two (2) times a year and more often if deemed necessary by the Chairman, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee.

N. Ethics Committee

1. Composition - The committee membership shall consist of a multi-disciplinary representation with at least half of its members from the Active Medical Staff and the remaining membership to include nurses, clergy, Social Services, Administration, and others. The Chairman shall be appointed by the Chief of Staff and approved by the Hospital Board of Trustees; committee membership will be recommended by the committee chairman and approved by the Executive Committee and the Board of Trustees; initial membership term will be for a minimum of two (2) years on same rotation as medical staff committees. To ensure continuity, some members should be retained. Ad-hoc consultants and members may be requested to attend or be consulted as deemed appropriate by the committee chairman based on the issue at hand.

2. Duties - The duties of the Ethics Committee shall be:

   a. To serve as an advisory body to members of the Hospital's medical, nursing and administrative staff on matters relating to moral and ethical decisions presented while rendering care and treatment.

   b. To educate the professional staff in current medical ethical concepts.

   c. To develop ethical guidelines that enhance the quality of patient care.

   d. To provide advice to other staff committees.

   e. To facilitate communication in sharing information so that mutual understanding between the health care providers and affected parties is maintained.

   f. To give advice upon request of providers faced with difficult, ethical issues in individual patient care. Such advice shall not replace the ultimate responsibility of the attending physician in such matters.

3. Meetings - The committee shall meet at least four (4) times a year, and more often if deemed necessary by the chairman.

1. Continuous Medical Education (CME)

2. Composition - The Committee shall consist of at least one member from each medical department, the CME Coordinator and representatives of Administration, Quality Management and Nursing Education.

3. Duties - The CME Committee shall be responsible for the Brandon Hospital CME Program for the Medical Staff. Specifically, the committee's duties shall be:

   a. Oversite of the Medical Staff's Educational Program.
b. Assessment of Medical Staff educational needs.

c. Evaluation and approval of Medical Staff education programs.

d. Maintain CME certification status through Florida Medical Association.

4. Meetings - The Committee shall meet at least four (4) times a year, and more often if deemed necessary by the Chairman, maintain a permanent record of its proceedings and actions. The members shall serve overlapping terms to ensure continuity.

P. Bylaws Committee

1. Composition - The Chief of Staff shall biennially appoint a Bylaws Committee. The Chief of Staff will serve as Chairman of this Committee.

2. Duties - Shall perform the key function of Bylaws Review and Revision, under the oversight and direction of the Medical Executive Committee. The Committee shall review these Bylaws and Rules and Regulations and recommend any needed additions, revisions, modifications, amendments or deletions and shall report them to the Medical Executive Committee.

3. Meetings - The committee shall meet at least once every two years.

Q. Special Committees

1. Special Committees shall be appointed from time to time as may be required to carry out the duties and functions of the Medical Staff properly. These committees shall report to the Executive Committee, and they shall have no power to act unless specifically granted by the Executive Committee.

XIV. Immunity from Liability

A. The following shall be express conditions to any practitioner’s membership in the Medical Staff, application for, or exercise of, clinical privileges at this Hospital

1. First, that the applicant/member shall release from liability the Hospital and all other persons participating in any act, communication, report, committee recommendation, or disclosure with respect to any such physician, dentist, podiatrist, licensed psychologist or Health Professional Affiliate, performed or made in good faith and without malice for the purpose of achieving and maintaining quality patient care in this or any other health care facility.

2. Second, that such release shall extend to members of the Hospital’s Medical Staff and Governing Body, its other practitioners, its Chief Executive Officer and staff or representatives, and to third parties, who supply information to any Hospital or Medical Staff Committee or department of the foregoing. For the purpose of this Article, the term “third parties” means both individuals and organizations from whom information has been requested or to whom it has been released by an authorized representative of the Hospital, Governing Body, the Medical Staff or any committee thereof.

3. Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure.

4. Fourth, that such immunity shall apply to all acts, communications, committees, reports, recommendations or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to:

a. Applications for appointment, clinical privileges or specified services;
b. Periodic reappraisals for reappointment, clinical privileges or specified services;

c. Disciplinary action, including any statutory reporting requirement.

d. Hearings and appellate reviews;

e. Utilization reviews; and

f. Other Hospital department, section, or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

5. Fifth, that the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to an applicant's, member's, or practitioner's professional qualifications, clinical competence, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly affect patient care.

6. Sixth, that each applicant, member or practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations set forth.

7. Seventh, that all information received by any practitioner or Advanced Practice Professionals (APP) in connection with any investigation, committee, disciplinary action or any other service to the Medical Staff or Hospital is privileged and confidential and shall be held in confidence by the practitioner or Advanced Practice Professionals (APP) to the fullest extent required by law.

8. Eighth, that the consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws for the protection of this Hospital, Hospital's practitioners, other appropriate Hospital officials and personnel and third parties, shall be applicable also to applications for initial appointment.

9. Ninth, that each applicant to the Medical Staff, each Medical Staff member, each practitioner and each person subject to approval and review under these Bylaws consents to such privileges, release, and immunities under the terms and conditions described in this Article and these Bylaws and the Bylaws and policies of the hospital.

XV. Medical Staff authority and responsibility

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions. The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards. The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations and Policies shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Medical Staff Rules and Regulations and Policies may contain the associated detail for provisions in the Medical Staff Bylaws. "Associated details" are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws. The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and the Board of Trustees shall uphold the Medical Staff Bylaws that have been approved by the Board of Trustees.

XVI. Rules and Regulations

A. The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws subject to the
approval of the Governing Body. These shall relate to the proper conduct and guidelines of Medical Staff activities, as well as, embody the level of practice that is to be required of each practitioner in the Hospital.

B. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular or special meeting of the Medical Staff at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those active staff members present. Such changes shall become effective when approved by the Governing Body.

C. Each Department (and Section) may adopt such Rules and Regulations as may be necessary for the proper conduct of its intra-departmental (and intra-section) functions provided that they are not at variance with the Bylaws and Rules and Regulations of the Medical Staff or the Hospital. The Department (and Section) Rules and Regulations shall be appended to the general Rules and Regulations. The method of adoption or amending Department (and Section) Rules and Regulations shall be at the discretion of the individual department (or section thereof), but the Rules and Regulations shall be subject to approval by the Executive Committee and the Governing Body.

XVII. Amendments

A. These Bylaws are developed and may be amended, subject to the approval of the Executive Committee and Governing Body, except as otherwise provided, at any regular or special meeting of the Medical Staff provided that all Active members of the Medical Staff are notified by mail of the proposed amendments at least seven (7) days before the meeting at which the amendments are considered.

B. Amendments may be proposed by the Executive Committee or the Governing Body or in writing to the Executive Committee by at least fifteen (15) members of the Active Staff. Except as otherwise provided, the amendments to be adopted shall require a majority vote of those members of the Active Staff present at the meeting, provided a quorum is present, and shall become effective only when approved by the Governing Body.

C. The Medical Staff Bylaws, Rules and Regulations and policies, and the Governing Board Bylaws shall not conflict. The Medical Staff Bylaws are subject to the Governing Board’s approval.

XVIII. Medico-Administrative Positions

A. Any practitioner whose contractual engagement by the Hospital requires membership on the Medical Staff shall not have his/her Medical Staff membership or admitting and clinical privileges terminated without the right to hearing and appeal as provided for in the Bylaws, unless otherwise provided in the engagement contract. The practitioner may agree in the contract that his/her Medical Staff membership and privileges may terminate upon termination of the contract, and such contractual agreement shall control.

XIX. Patient Admission

A. Every patient must be admitted by a member of the Medical Staff in good standing and remain under the primary care of a physician member in good standing of the Medical Staff with the appropriate privileges.

XX. Adoption

A. These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff and upon becoming effective, shall constitute a repeal of all prior Bylaws and Rules and Regulations. Medical Staff Bylaws and Rules and Regulations shall become effective when approved in accordance with the Bylaws of the Governing Body. Each member of the Medical Staff shall abide by the Medical Staff Bylaws and Rules and Regulations and policies as amended by adoption. These Bylaws and Rules and Regulations shall be reviewed by a committee at least once every two years and
revised when timely and appropriate. Nothing contained in these Bylaws and Rules and Regulations shall preclude the Governing Body from exercising its authority notwithstanding these Bylaws or otherwise, when required to meet the Governing Body's responsibility for the conduct of the Hospital. These Bylaws shall be subject to the Bylaws of the Governing Body.

XXI. Conflict Management Resolution -- Conflict Resolution Between the Medical Staff and the Medical Executive Committee

The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff, the representatives of the Medical Staff, or the Chairperson of the Board of the Governing Body may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Resolution Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Medical Executive Committee-Medical Staff conflicts, the Joint Resolution Committee shall be composed of:

Three officers of the Medical Staff
Three voting members of the Medical Staff representing the recommendations in the written petition
The Chairperson of the Governing Board
The Chief Executive Officer or designee

If the Joint Resolution Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The Medical Executive Committee and Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Medical Executive Committee and the Medical Staff shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee.

XXII. Substantial Compliance

Minor deviations from the procedures set forth in these bylaws shall not be grounds for invalidating the action taken.
Medical Staff Rules and Regulations

A. Meeting Dates

1. The quarterly meeting of the Medical Staff shall be held at a place and time designated by the Chief of Staff. The annual meeting of the Medical Staff will be held in November.

2. Department meetings will be held at least quarterly or as determined by the Chairmen of the Departments.

3. Reports of all committee and department meetings will be submitted to the Executive Committee.

B. Medical Staff Performance Improvement

The Medical Staff shall engage in performance improvement functions for the purpose of improving care provided at the facility. These functions shall be performed by such committees and/or individuals as may be designated by the Executive Committee.

When the findings of the assessment process are relevant to an individual’s performance, the organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner’s competence. Processes shall include ongoing professional practice evaluations through the measurement, monitoring, analysis and improvement of the quality and appropriateness of services provided by individual medical staff members and other individuals with clinical privileges.

When the performance of a process is dependent primarily on the activities of individuals with Clinical Privileges, the Medical Staff shall provide leadership for and participate in process measurement, assessment, improvement, and evaluation including, but not limited to:

a. activities related to patient safety
b. medical assessment and treatment of patients;
c. use of information about adverse privileging decisions for any practitioner privileged through medical staff processes
d. use of medications
e. invasive procedures which place patients at more than minimal risk
f. appropriateness of clinical practice patterns
g. significant departures from established patterns of clinical practice
h. analyzing and improving patient satisfaction.
i. the use of developed criteria for autopsies.

Information used as part of the performance improvement mechanisms, measurement or assessment includes:

   Sentinel event data
   Patient safety data.

The Medical Staff also participates in the measurement, assessment, improvement and evaluation of other care processes. These include, though are not limited to:

1. education of patients and families, including the reduction of medical error;
2. coordination of care, treatment and services with other practitioners and Institute personnel, as relevant to the care of an individual patient; and,
3. accurate, timely and legible completion of patients medical records.
A description of the committees that carry out systematic monitoring and performance improvement functions, including composition, duties and reporting is included in these Bylaws, Organizational Performance Improvement and Patient Safety Plans.

C. Admission of Patients

1. The Hospital shall admit patients suffering from all types of diseases except custodial psychiatric disorders.

2. Patients may be admitted to the Hospital only by practitioners who have been duly appointed to the Medical Staff by the Governing Body. All practitioners shall be governed by the official admitting policy of the Hospital. All orders for outpatient tests will be accepted for licensed Florida practitioners.

3. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. Whenever such consent has not been obtained by the Admitting Department, it is the practitioner's responsibility to obtain proper consent before the patient is treated in the Hospital.

4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.

5. In case of an emergency admission, the provisional diagnosis and admission note shall be hand written by the admitting practitioner and placed in the chart within 24 hours of admission. An emergency is defined as a condition in which the life of the patient is in immediate danger, or in which any delay of administering treatment would increase that danger.

6. Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee, the Chief Executive Officer, and the Utilization Review and Medical Records Committee that said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient’s chart.

7. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions and, if applicable, for transmitting reports of the condition of the patient to the referring practitioner and family. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the physician’s order sheet of the medical record. Transfer is complete only upon acceptance of the receiving physician.

8. The admitting physician or covering physician shall attend patients within 24 hours of any inpatient or observation admission.

9. Patients are to be evaluated within 24 hours of admission by admitting physician or designee and notes are to be written in charts within 24 hours of admission. Daily notes are to be written by attending physician.

10. The practitioner admitting a patient shall be responsible for giving such information that may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever. Any patient who, on admission or after admission, is discovered or suspected of having an infectious disease must be placed in isolation in accordance with the Hospital’s isolation policies and procedures.
11. Patients shall be attended by a member of the Medical Staff as selected by the patient, but in every case, the Hospital shall endeavor to have the patient placed in the clinical service of the member who is best qualified to render service, and in all instances, members of the Medical Staff shall collaborate as required in the best interests of the patient.

12. A patient to be admitted on an emergency basis who does not have a private practitioner may request any practitioner in the applicable clinical service to attend him. When no request is made, a practitioner will be assigned, on a rotation basis, as determined by the Chairman of the respective Departments.

13. A practitioner who will be absent for over 24 hours should indicate in writing on the patient's chart the name of the practitioner who will be assuming responsibility for the care of the patient.

14. The Medical Staff shall define the categories of medical conditions and criteria to be used to implement patient admission priorities. These shall be developed by each department, approved by the Executive Committee and shall include Emergency Admission, Urgent Admission, Pre-Operative Admission and Elective Admission.

15. If any question as to the validity of admission to or discharge from any Special Care Unit should arise, the decision is to be made through consultation with the attending practitioner and the Chairman of that respective Special Care Unit.

16. The attending practitioner is required to document the need for continued hospitalization after specific periods (extended durations) of stay as identified by the Utilization Review and Medical Records Committee and approved by the Executive committee. This documentation must contain:

a. an adequate written record of the reason for continued hospitalization;
b. the estimated period of time the patient will remain in the Hospital;
c. plans for post-hospital care; and
d. signature and date.

D. Discharge of Patients

1. Patients shall be discharged only on an order of the attending practitioner or a designated alternate representative of the Medical Staff.

2. Any patient leaving the Hospital without the consent of the attending practitioner shall be required to sign a statement that he/she (statement signed by legal guardian, if applicable) is voluntarily leaving the Hospital against the advice of the practitioner and that in so doing absolves the practitioner and the Hospital from any and all responsibilities presently or subsequently resulting therefrom.

3. Passes for patient to leave the Hospital are not permitted except at the discretion of the attending practitioner who must indicate by written order the nature and time limits of the pass. A release of responsibility form must be signed by the patient.

4. At the time of discharge, the attending practitioner shall see that the patient's medical record is satisfactorily completed; record the final diagnosis, the prognosis, the local and general conditions of the patient, the advisable subsequent care and the name of the practitioner to whom the patient is directed to report for any further medical attention. A temporary suspension in the form of withdrawal of admitting privileges or scheduling of elective surgical cases effective until the final diagnosis are completed on the face sheet, may be imposed automatically after warning a member of his/her delinquency and his/her failure to complete such medical records within 24 hours after such warning.
E. **Medical Records**

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. This record shall be current and include identification date; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and other diagnostic and/or therapeutic studies; provisional diagnosis; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed.

   A. A complete admission history and physical examination shall, in all cases be written or dictated within 24 hours after admission of a patient.

   B. If an H&P has been performed and documented within thirty (30) days of the patient's admission to the hospital or admission for a scheduled operative or invasive procedure, a legible copy of that H&P examination may be used in the patient's medical record, provided an update is performed by a licensed independent practitioner or designee with privileges to perform H&Ps, and it is documented prior to the procedure or at the time of or within 24 hours of admission. This update may be written or otherwise recorded on, or attached to, the previous H&P, or written in a progress or consult note.

2. When the history and physical examination are recorded but not on the chart prior to surgery or any potentially dangerous diagnostic procedure, such operation or procedure shall be canceled.

3. When such history and physical are not dictated before the time of the operation, the operation shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient’s health and welfare.

4. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Qualified Physician, a Qualified Oral maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

5. An admitting note briefly summarizing the patient's condition on admission, the reason for hospitalization, and the treatment proposed shall be written by the attending practitioner within 24 hours of admission.

6. If a patient is readmitted within 30 days with the same condition on admission, the reason for hospitalization, and the treatment proposed shall be written by the attending practitioner within 24 hours of admission.

7. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care. The patient's clinical problems should be clearly identified in such notes and correlated with specific orders as well as treatment. The attending practitioner shall write progress notes at least daily or at intervals appropriate to the case so as to accurately reflect the patient's course in the Hospital. Progress notes shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of clinical problem.
8. All operations performed for outpatients and inpatients shall be fully described by the attending surgeon in an operative report dictated and a progress note written immediately after surgery which contains a description of the findings, technical procedures used, specimen(s) removed, post-operative diagnosis and the name of the primary surgeon and any assistant. This report must be promptly signed and made a part of the patient's current medical record.

9. All clinical entries in the patient's medical record shall be accurately dated and authenticated. Authentication means written signature or identifiable initials.

10. This facility has identified a list of dangerous abbreviations and dose designations that must not be used when documenting in any portion of the medical record. Refer to the Policy, "Abbreviation Do Not Use", which is located in the hospital's Policy & Procedures (located in CPCS) for the current list of these do not use abbreviations and dose designations.

11. The final diagnosis shall be recorded in full, without the use of symbols or abbreviations and dated and signed by the responsible practitioner at the time of discharge of all patients except where pathological tissue report is not available.

12. A discharge clinical summary shall be written or dictated on all medical records for patients hospitalized over 48 hours. A final summation progress note is acceptable for admissions less than 48 hours, normal newborns or normal vaginal deliveries. Short forms may be appropriate for such conditions as tonsillectomies, cystoscopies, lacerations, plaster casts, removal of superficial growths and minor outpatient surgical procedures. This form should at least contain a brief resume of the patient's condition, pertinent physical findings, treatment given and other data to justify the diagnosis and treatment. The record should be signed by the attending practitioner.

13. All medical records are the property of the hospital. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a Court Order, Subpoena or Statute for the purpose of appearance in court, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information Management systems, for processing.

14. In case of readmission of a patient, all previous records shall be available for use by the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of medical records by a practitioner from the Hospital is grounds for disciplinary action as determined by the Executive Committee and Chief Executive Officer.

15. Free access to all medical records for patients shall be afforded to practitioners in good standing for bona fide study and research consistent with preserving the confidentiality of personal information concerning individual patients, as review related to Medical Staff committee functions or as approved by the Executive Committee.

16. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

17. Subject to the discretion of the Chief Executive Officer and the Utilization Review and Medical Records Committee, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

18. All medical records shall be completed within thirty (30) calendar days after the patient's discharge or shall be considered delinquent. Any practitioner having delinquent medical records shall have his/her admitting, consulting, surgical privileges suspended until such
time as the delinquent records are completed to the satisfaction of the hospital. Exceptions to this regulation may be made in the event the Chief Executive Officer is informed in writing of an illness or absence from the city. Any practitioner suspended three (3) times within any twelve (12) month period for delinquent records shall be subject to disciplinary action as provided in Article VII of the Bylaws of the Medical Staff.

19. The Medical Records Committee shall function as provided in Article XIII of these Bylaws and shall have authority to review any and all records to insure compliance with the Bylaws of the Medical Staff and these Rules and Regulations.

20. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Records Committee.

21. Upon receipt by the Hospital of a written consent and request from a former patient of the Hospital and his/her chiropractor, on a form satisfactory to the Hospital, a copy of the Hospital's diagnostic x-ray and laboratory reports on such patient may be furnished to a chiropractor who is duly licensed by the State of Florida. All consents and requests for such reports shall designate with reasonable certainty the date of such tests.

I. Standing Orders and Drug

I. Standing orders shall be formulated by conference between the Medical Staff and Chief Executive Officer, and may be changed by the Chief Executive Officer only after consultation with Medical Staff. These orders shall be followed insofar as proper treatment will allow and when specific orders are not written by the attending practitioner they shall constitute the orders for treatment.

II. All orders for treatment shall be in writing. Practitioners orders dictated over the telephone shall be received and signed by a licensed nurse. Telephone orders may be relayed by the practitioners authorized medical personnel. Telephone orders may also be received and signed by a respiratory therapist, physical therapist, speech therapist, occupational therapist, pharmacist, or dietitian when such orders relate to the scope of these individual's professional licensure. The licensed professional shall indicate the name of the individual giving the order as well as their own. The responsible practitioner shall authenticate such orders by signature as soon as possible.

III. The practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the Nurse. The use of "Renew", "Repeat" and "Continue Orders" is not acceptable.

IV. All previous orders are canceled when a patient goes to surgery.

V. Unless the duration of medication administration is specified by the ordering physician, the following automatic renewal order timeframes will apply:

XIV. Renewal orders for all Schedule II drugs will be required at the end of 3 days.

XV. Renewal orders for albuminNIG will be required at the end of 3 days.

c. Renewal of Ketorolac will be required at the end of 5 days.

d. All other drugs will require renewal after 30 days.

VI. A stop order on Inhalation Therapy and on drugs ordered in connection with such therapy will be automatically effective at the end of 72 hours when a specific course of treatment has not been ordered.

VII. Drugs used shall meet the standards of the United States Pharmacopeia, National Formulary, New and Non-Officio Drugs, with the exception of any drugs for bona fide clinical investigation.

VIII. Medication brought into the Hospital by patients may not be administered until prescribed by written orders of the attending practitioner after he has certified in the written orders as
to the identification of the medication. Without such written orders, all medications brought into the Hospital by patients will be packaged, sealed and returned to the patient at the time of discharge.

IX. The Hospital utilizes a formulary approved by the Medical Staff. Pharmacists may therapeutically substitute medications with the approval of the Medical Staff.

G. Surgery

1. The Chairman of the Department of Surgery will have the responsibility and authority for the overall medical management of the O.R. Suite.

2. Informed surgical consent shall be obtained by physician and shall be written and signed prior to the operative procedure except in those situations in which the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient.

3. Emergencies involving a minor or an unconscious patient in which consent for surgery cannot immediately be obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation may be desirable before the emergency operative procedure is undertaken, if time permits.

4. Should a second operation be required during the patient's stay in the Hospital, a second, written, signed and informed consent, specifically worded, should be obtained. If two or more procedures are to be carried out at the same time, and this is known in advance, they may all be described and consented to on the same form.

5. A history and physical examination and admission note shall be recorded on the medical record before the stated time of surgery or the operation shall be canceled unless the attending surgeon states in writing that such delay would be detrimental to the patient in which case an admission note, including heart and lungs, shall be required.

6. All operations shall be fully described by the attending surgeon and recorded as part of the patient's medical record immediately following the procedure.

7. All tissues and foreign objects removed at operations except those specifically approved by the Medical staff to be excluded shall be sent to the Hospital Pathologist who shall make such examination as he may consider to arrive at a pathological diagnosis. His authenticated report shall be made a part of the patient's medical record.

8. Surgeons shall be in the operating room and ready to commence the operative procedure at the time scheduled unless delayed by an emergency or other unavoidable circumstances, in which event, they shall notify the Operating Room Supervisor. Should such delay in schedule conflict or interfere with other scheduled operations, the operating room shall not be held longer than 15 minutes and the operation subsequently canceled.

9. The Anesthesiologist shall maintain a complete anesthesia record to include a pre-anesthetic evaluation and post-operative follow-up with time, date and findings recorded.

10. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed. Each surgeon is responsible for determining when a procedure presents an unusual hazard to life.

11. All surgical patients undergoing local, spinal, regional blocks or general anesthesia must have the following studies in the chart prior to surgery:

a. A pregnancy test will be required for all menstruating women between the ages of 12-50, within one week of surgery. Exception: The pregnancy test is not required for
women who are having surgery related to missed or incomplete abortions.

b. All other diagnostic testing will be ordered on an individualized basis as deemed necessary by the physicians during the pre-operative assessment of the patient.

12. Surgical privileges for a practitioner are delineated as recommended by the Credentials Committee, action of the Executive Committee and approval of the Governing Body.

13. Only those practitioners having full surgical privileges shall be permitted to assist in the operating room, and only those procedures as recommended by the Credentials Committee, action of the Executive Committee and approval of the Governing Body.

H. Consultations

1. Routine consultations, unless specified otherwise by the referring physician, must be seen or refused within a 24-hour period after notification.

2. Any practitioner admitting a patient to the Intensive Care Unit with a diagnosis which does not fall into that practitioner’s direct specialty, must obtain a consult from physician within the specialty.

3. A consultant must be well qualified to give an opinion in the field in which his opinion is sought. Consultant expertise is determined by the Medical Staff on the basis of training, experience, competence and current capability.

4. Consultations must be ordered in writing by the attending practitioner. Consulting practitioners may not write orders unless authorized by the attending practitioner. Practitioners requesting a consult will indicate on the appropriate form the extent the consultant may participate in the patient’s care.

5. It is the duty of the Hospital Staff, through the Chairmen of the Departments and the Executive Committee, to see that members of the Medical Staff implement the rules for required consultations.

6. Satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the patient’s medical record. When operative procedures are involved, the consultation note shall be recorded prior to the operation.

7. In the event that a practitioner is unable to accept a consult for a specific patient, the Emergency Room On-Call Physician would provide the consultation. If at that point, the On Call Physician refuses to see the patient, then the Chairman of the Department would then be contacted to resolve the consultation request.

8. If a nurse has any reason to doubt or question the care provided any patient or believes that appropriate consultation is needed and has not been able to resolve the situation through the attending physician, he/she shall call this to the attention of his/her supervisor who may refer the matter to the Director of Nursing or Hospital Administration. If warranted, the matter will then be brought to the attention of the Chairman of the Department in which the practitioner has clinical privileges or in his/her absence the Chief of Staff who may request a consultation where circumstances justify such action.

I. Necropsies

1. In the event of a hospital death, the deceased shall be pronounced dead by a practitioner on the Medical Staff within a reasonable time and the body shall not be released until a notation is made in the patient’s medical record.
2. Every member of the Medical Staff shall be actively interested in securing necropsy permission whenever possible for deaths meeting criteria established by the medical staff. No necropsy shall be performed without the written consent of the responsible relative or legally authorized agent as determined by Florida law.

3. All necropsies shall be performed by the Hospital Pathologist or by a practitioner delegated this responsibility unless required by law to be performed by the Medical Examiner in the County the Hospital is located.

4. For all necropsies, provisional anatomic diagnosis shall be recorded on the medical record within two working days and the complete protocol a part of the record within 30 working days for routine cases and 90 days for complicated cases.

J. Emergency Services

1. The Chief Executive Officer and the Medical Staff shall adopt a method of providing medical coverage of the Emergency Department. This method shall be comprised of full-time practitioners who are duly appointed to the Medical Staff by the Governing Body including a delineation of their clinical privileges. These practitioners will render emergency care and the patient will be referred to his private practitioner for follow-up. When necessary to assure the provision of quality patient care and compliance with federal and state law governing the provision of emergency medical services to individuals who require treatment to stabilize an emergency medical condition, the Executive Committee shall have the right to require physicians who are appointment to the medical staff and granted clinical privileges in certain specialties or areas of expertise where there is a deficiency in the number of such physicians to provide on call coverage to the Emergency Department.

2. It shall be the responsibility of the group practice to cover all call that was originally assigned to a physician who has left their practice.

3. A solo practitioner, joining the medical staff, may be required to take emergency room call. Arrangements may be made with other groups to assist with coverage, however, must be noted in writing by both parties.

4. An appropriate medical record shall be maintained for every patient receiving emergency service and be incorporated in the patient's medical record, if such exists.

5. At Brandon Regional Hospital, a Medical Screening Examination (MSE) must be completed on each Emergency Department patient. The MSE will be completed by Qualified Medical Personnel, defined as a credentialed Emergency Physician, Physician Assistant, or Advanced Registered Nurse Practitioner, who has demonstrated current competency to complete the MSE and approved by the Department of Emergency Medicine (12/4/06).

For the assigned laboring or assigned potentially laboring patient, the MSE may be completed by "Qualified Medical Personnel" in Labor and Delivery in consultation with the patient's obstetrician. "Qualified Medical Personnel" is defined as Labor and Delivery registered nurses who have demonstrated current competency to complete the MSE and have been approved by the Department of OB/GYN to do so. An assigned laboring or potentially laboring patient is a patient with an established patient/physician relationship with an obstetrician or obstetrical group with current privileges to provide obstetrics medical management at Brandon Regional Hospital.
6. All non-assigned Emergency Department patients shall be attended by members of the Active Staff or licensed practitioner in attendance in the Emergency Room and shall be assigned to the service concerned in the treatment of the disease which necessitated admission, or in rotation if there is no service division.

7. If a patient does not have a private practitioner, he shall be assigned to the member of the Active or Provisional Staff On-Call in the service to which the illness or condition of the patient indicates treatment. A practitioner on-call cannot refuse to see an Emergency Room patient or refuse at least one (1) follow-up visit by a healthcare provider. Any violations of this policy will be referred to the Executive Committee for possible disciplinary action.

8. As part of the Hospital's Disaster Plan, members of the Medical Staff shall be assigned to positions, either in the hospital or some other designated location for specific medical action.

9. The Hospital Disaster Plan will be rehearsed at least twice a year and it is the responsibility of practitioners to participate in and report to their assigned stations.

10. All policies concerning patient care as it relates to disasters will be the responsibility of the Chairman of the Departments, the Chief Executive Officer, and the Hospital Disaster Committee.

K. Monitoring and Evaluation - Physician Responses

1. When requested, physicians will respond to medical staff department or committee inquiries within four weeks after receipt of request. Any response not received within four (4) weeks shall require a second notification and shall be referred to Executive Committee.

L. Adoption

1. The Rules and Regulations and subsequent changes shall become effective when adopted at a meeting of the general staff and approved by a majority vote of the Governing Body of the Hospital and shall constitute a repeal of all prior Rules and Regulations.