SAINT FRANCIS MEDICAL CENTER

SAINT FRANCIS MEDICAL CENTER

MEDICAL STAFF

Bylaws
Rules & Regulations

Revised December 2013

PREAMBLE

WHEREAS, the Saint Francis Medical Center is a nonprofit corporation organized under the laws of the State of Missouri; and

WHEREAS, its purpose is to serve as a general, acute care medical center providing patient care, and participating in education and research; and

WHEREAS, it is recognized that the Medical Staff is to strive for quality patient care in the medical center, the Medical Staff's activities involve working with, and are subject to, the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, management, and the Board are necessary to fulfill the objective of providing quality patient care to its patients;

THEREFORE, the physicians, dentists and podiatrists practicing in this medical center shall carry out the professional functions authorized by the Board in conformity with these bylaws.

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MEDICAL STAFF
BYLAWS
RULES & REGULATIONS
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DEFINITIONS

1. PROXIMATE AREA of the medical center means the physical distance or geographic radius in which a physician shall reside and practice to ensure reasonable availability to care for his/her patients as may be determined by the Board of Directors considering a variety of factors related to the physician's practice, including the nature of the specialty, medical center requirements, risk exposure, and the availability of back-up coverage.

2. BOARD OF DIRECTORS or BOARD means the Board of Directors of Saint Francis Medical Center.

3. CLINICAL PRIVILEGES means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric or surgical services.

4. COMPLETED APPLICATIONS means the information on file regarding the Medical Staff application has been received and verified to the satisfaction of the Credentials Committee.

5. DENTIST means an individual who has been awarded the degree of doctor of dentistry (DDS) or doctor of dental medicine (DDM).

6. 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.

7. EXECUTIVE STAFF means the President/CEO, Vice Presidents, Chief Information Officer, Director of Human Resources, Director of Facilities Management and Executive Foundation Director (when applicable) of the organization.

8. FAIR HEARING PLAN means the procedures set forth in Article VIII.

9. GOOD STANDING means the staff member is not under a suspension of his/her appointment or privileges.

10. HOSPITAL-BASED PHYSICIAN means a physician the majority of whose practice is hospital based. For example: Anesthesiologist, Emergency Medicine, Pathologist, Radiologist, Hospitalist, Neonatologist, Perinatologist, or other physician.

11. MATERIALLY PARTICIPATE means to act as the admitting, attending, or physician of record of an inpatient, or to provide medical or surgical consultation customary to the physician's designated specialty.

12. MEDICAL CENTER means Saint Francis Medical Center.

13. MEDICAL STAFF EXECUTIVE COMMITTEE or MSEC means the executive committee of the Medical Staff.

14. MEDICAL STAFF or STAFF means the formal organization of all licensed physicians, dentists, and podiatrists who are privileged to attend patients in the medical center.

15. MEDICAL STAFF YEAR means the period from January 1 to December 31.

16. PHYSICIAN means an individual who has been awarded the degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO).

17. PODIATRIST means an individual who has been awarded the degree of doctor of podiatric medicine.

18. PRACTITIONER means, unless otherwise expressly limited, an appropriately licensed physician, dentist, or podiatrist applying for, or exercising clinical privileges in this hospital.
19. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in these bylaws and in other hospital and Medical Staff policies.

20. PRESIDENT/CEO OF THE MEDICAL CENTER means the individual appointed by the Board to act on its behalf in the overall administrative management of the medical center.

21. SPECIAL NOTICE means written notification sent by certified mail, return receipt requested.

22. SPECIFIED PROFESSIONAL PERSONNEL means psychologists, advanced practice nurses including certified registered nurse anesthetists, and physician assistants whose patient care activities require that their authority to perform specified patient care services be processed through Medical Staff channels or with involvement of Medical Staff channels or with involvement of Medical Staff representatives. Some other limited health practitioners will be processed via medical center channels.

23. VOLUNTARY RELINQUISHMENT means a limitation or cessation of privileges incurred by a practitioner resulting from an act or omission of the practitioner as an occurrence of the operation of these bylaws, rather than a positive action taken by the Medical Staff Executive Committee or the Board.

ARTICLE I
NAME

The formal name of the Medical Staff shall be the Medical Staff of Saint Francis Medical Center.

ARTICLE II
PURPOSES AND RESPONSIBILITIES

2.1 Purposes

The Medical Staff of Saint Francis Medical Center exists for the following purposes:

a. To be the formal organizational structure through which:

(1) The benefits of membership on the staff may be obtained by individual practitioners; and

(2) The obligations of the staff membership may be fulfilled.

b. To serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the medical center is consistently maintained at an appropriate level of quality and efficiency consistent with the state of the healing arts and the resources locally available.

c. To provide a means through which the staff may participate in the medical center's policy-making and planning process.

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

2.2 Responsibilities

The responsibilities of the staff, to be fulfilled through the actions of its officers, departments, and committees include:

a. To account to the Board for the quality and appropriateness of patient care rendered by all practitioners including specified professional personnel authorized to practice in the medical center through the following measures:

(1) A credentials program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specific services to be performed, with the verified credentials and current demonstrated performance of the applicant, staff member, or specified professional personnel.

(2) A continuing education program, fashioned at least in part on the needs demonstrated through the quality/utilization management program.

(3) The establishment and enforcement of criteria and standards for departmental credentialing.

(4) A utilization management program to allocate inpatient and outpatient medical and health services based upon patient specific determinations of individual medical needs.

(5) An organizational structure that allows continuous monitoring of patient care practices.

(6) Review and evaluation of the quality of patient care through a valid and reliable quality assessment procedure.

(7) Assist the medical center in the development of policies and procedures for improving patient safety and satisfaction.

b. To recommend to the Board action with respect to appointments, reappointments, staff category, departmental section assignments, clinical privileges, corrective action, and to close departments or grant exclusive contracts or arrangements.

c. To account to the Board for the quality and efficiency of patient care rendered to patients in the medical center through regular reports and recommendations concerning the implementation, operation, and results of quality assessment and performance improvement activities.

d. To initiate and pursue corrective action with respect to all practitioners and limited licensed practitioners, when warranted.

e. To develop, administer, and seek compliance with these bylaws, the rules and regulations of the staff, and other patient care related medical center policies.

f. To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

g. To exercise the authority granted by these bylaws and the Board as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE III
STAFF MEMBERSHIP

3.1 Nature of Staff Membership

Membership on the Medical Staff of Saint Francis Medical center is a privilege which shall be extended at the discretion of the Board of Directors (Board) on the basis of a favorable recommendation from the Medical Staff Executive Committee (MSEC). Except as may be required by the laws of the United States and the State of Missouri, no person shall be entitled to apply for or obtain membership solely on the basis of the holding of any particular license or certification. Neither shall any person be entitled to exercise any privilege or perform any procedure, test, or treatment or prescribe any medication solely upon the basis that such person has been licensed, privileged, certified, or credentialed by any particular agency, board, institution, or other entity. Appointment to and membership on the staff shall confer on the staff member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these bylaws and shall include staff category and department section assignments.

3.2 Basic Qualifications for Membership

a. **Basic Qualifications** - Only physicians, dentists and podiatrists licensed to practice in the State of Missouri shall be qualified for membership on the Saint Francis Medical Center Staff and who:

(1) Document their experience, background, training, demonstrated ability; and upon request, their physical and/or mental health status, with sufficient adequacy to demonstrate to the staff and Board that they will provide care to patients at the generally recognized professional level of quality, in an economically efficient manner, taking into account patients' needs, the available medical center facilities and resources, and utilization standards in effect at the medical center.

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities.

(3) Provide evidence of professional liability insurance coverage in an amount determined by the Board or other evidence of financial responsibility satisfactory to the Board.

When the MSEC or Board has reason to question the physical and/or mental health status of a practitioner, the practitioner shall be required to submit to an evaluation of his/her physical and/or mental health status by a physician or physicians acceptable to the MSEC, as a prerequisite to further consideration of his/her application for appointment or reappointment, to the exercise of previously granted privileges, or to maintenance of his/her staff appointment.

b. **Nondiscrimination** - Staff membership or particular clinical privileges shall not be denied on the basis of any criterion unrelated to the efficient delivery of patient care at the level of quality deemed necessary and proper by the Board. The privilege of application or membership shall not be denied on the basis of sex, race, creed, color, or national origin. This provision shall not restrict the authority, responsibility, or discretion of any

committee or the Board to consider the existence of any physical impairment or disability as it affects the ability of any practitioner to carry out the safe practice of medicine in an efficient manner in the granting of any rights and privileges pursuant to these bylaws.

3.3 Basic Responsibilities of Staff Membership

Each member of the staff shall:

a. Provide for the continuous care of all inpatients and outpatients at the generally recognized professional level of quality and efficiency, by designating an alternate physician(s) with adequate training, as approved by the Credentials Committee or MSEC, to care for his/her patients when not available.

b. Abide by the Medical Staff Bylaws and Rules and Regulations, and by all other established standards, policies, and rules of the medical center.

c. Discharge staff, department, section, committee, and medical center obligations which have been assigned to him/her.

d. When listed as "on-call" by the medical center, provide, in a timely manner, appropriate consultations as requested for both emergency room patients, inpatients and for all other categories of patients.

e. Prepare and complete in a timely and legible manner the medical and other required records for all patients he/she admits or in any way provides care to in the hospital.

f. Abide by the ethical principles of the profession and any statement of the ethical guidelines which may be subsequently adopted by the medical center, which are incorporated herein by reference.

g. Promptly notify the President/CEO of the medical center of the occurrence of any of the following events: revocation, suspension, or restriction of the license to practice medicine or dentistry by any state or federal agency; revocation, suspension, or the imposition of conditions on the privilege to practice at any other health care facility; or of the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Missouri, the loss of malpractice insurance, or of the filing of a claim against the practitioner alleging professional liability.

h. Participate in an Emergency Services On-Call Schedule for the purpose of accepting for care and treatment of patients who, after being evaluated by an emergency services physician, are determined to require inpatient admission and who do not otherwise have a local physician. (Those patients who have a local physician will be referred to him/her or his/her designated alternate.)

i. Abide by the Religious and Ethical Directives for Catholic Health Facilities of the United States Catholic Conference of Bishops.

j. Report to the President/CEO any final judgments or settlements pertaining to professional liability action.

3.4 Duration of Appointments

a. **Duration of Initial Appointments** - Initial appointments shall be made to the associate, consulting, affiliate or courtesy category. Regardless of the category that the practitioner is assigned, the initial appointment shall be an initial period of 12 months, unless extended (provisional staff) as provided in these Bylaws.

b. **Reappointments** - Unless the provisional period is extended, reappointments to the Medical Staff shall be for a period of two (2) years, until the staff member attains the age of sixty five (65), after which reappointment shall be for one (1) year, unless otherwise specified in the notice of reappointment.

c. **Modifications of Appointees** - Any modifications of appointment or clinical privileges shall be for the period remaining in the appointment current at the date of such modification.

d. **Focused Evaluation of New Appointees** - The chair of the section or department to which a newly appointed Medical Staff member is assigned shall evaluate the new staff member during the one-year period or until such time as the chair notifies the appointee and the Credentials Committee that it is not necessary to continue such focused review. The chair shall direct the focused review to be performed according to the individualized monitoring plan approved by the Credentials Committee and MSEC (See the Medical Center's policy *Focused Professional Practice Evaluation.* In the event proctoring is implemented, it shall be carried out according to this policy). Upon a determination by the chair that monitoring is no longer necessary, the chair shall report in writing to the Credentials Committee, MSEC, and the Medical Staff President regarding the appointee's clinical skills, quality of care, and professional conduct**.**

e. **Ongoing Professional Practice Evaluations –** There shall be ongoing professional practice evaluations no less frequently than every six (6) months.

f. **Appointments Provisional** –

(1) If, at the end of this one-year period, the member has failed to materially participate in the care of a minimum of ten (10) cases or requires further assessment of his/her behavior or clinical competence with respect to all clinical privileges, then the MSEC, upon the written recommendations of the Credentials Committee and the chair of the department and/or section to which the practitioner was assigned, may elect to continue the provisional status of the practitioner's appointment to the Medical Staff category for an additional period of up to one (1) year. If provisional status is continued, the practitioner will not be entitled to hearing rights under these Bylaws. The provisional appointment shall then expire at the end of the second year, at which time the appointee must request removal of provisional status or advancement to the active**,** courtesy, or consulting Medical Staff. The request shall be referred to the chair of the applicable department. If the appointee does not satisfy the criteria for advancement based on the minimum number of cases (excluding consulting staff), or does not seek advancement of status, the provisional appointment shall expire without further consequence and the appointee is deemed to have voluntarily

relinquished his/her privileges. In such case there shall be no right of hearing or appeal.

(2) The method of supervision and review of the performance of a practitioner provisionally appointed to the associate**,** consulting or courtesy category of the staff shall be delineated by the chair of the department or section to which the practitioner is assigned and the Medical Staff President.

(3) During the provisional period, a member of the Medical Staff shall meet the Medical Staff meetings' requirements set forth in these Bylaws for the category of the Medical Staff to which he/she is seeking regular appointment, and shall have such other prerogatives and be subject to such other restrictions for that category of the staff as are set forth in these Bylaws.

(4) Provisional status may be terminated or a request for continuation denied upon recommendation of the department chair and approval by the MSEC. If the Board approves a recommendation from the MSEC to deny a request for continuation or to terminate provisional status, the practitioner shall be entitled to the rights of due process under these Bylaws.

g. **Contract Practitioners** - Notwithstanding any other provision of these Bylaws, the medical staff membership of any practitioner whose services are incident to a contract or other agreement for professional services between the physician or the physician's group and the medical center shall run concurrently with the term of the contract or agreement and with the term of the physician's affiliation with the group at the level of affiliation that existed when the original membership was granted.

3.5 Leave of Absence

a. **Leave Status** - A Medical Staff member may request a voluntary leave of absence from the staff by submitting a written request to the MSEC and the Medical Staff President, which states the period of time for the leave, which may not exceed the remainder of the current staff appointment. A leave of absence request may be granted by the MSEC, subject to such conditions or limitations as the MSEC shall determine to be appropriate. During the period of a leave, the staff member's privileges and prerogatives shall not be exercised.

b. **Termination of Leave** - At least thirty (30) days prior to the termination of the leave, or at any earlier time, the staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the Medical Staff President for transmittal to the MSEC. The staff member shall submit a written summary of his/her relevant activities during the leave, if the MSEC or the Board so requests. The MSEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges and prerogatives. Failure, without good cause, to request reinstatement or to provide a requested summary of activities, as above provided before termination of the leave, shall result in automatic termination of staff membership, privileges and prerogatives, without right of hearing or appellate review. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE IV
CATEGORIES OF THE STAFF

4.1 Categories

The staff shall be divided into honorary, active, associate, affiliate, consulting, and courtesy categories.

4.2 Active Staff

a. **Qualifications** - The active staff shall consist of practitioners who have been advanced from the associate staff and each of whom:

(1) Meets the basic qualifications set forth in Section 3.2;
(2) Has their primary professional practice office within the proximate area of the medical center; and
(3) Admits 10 or more patients to, or is otherwise actively involved in the care of 10 or more patients at the medical center in one year.

b. **Prerogatives** - The prerogative of an active staff member shall be to:

(1) Admit patients to the hospital according to his/her privileges:
(2) Exercise such clinical privileges as are granted to him/her pursuant to Article VI.
(3) Participate in Emergency Services on-call schedule coverage, subject to the Board-approved policies governing Emergency Services.
(4) Vote on all matters presented at general and special meetings of the staff, department, section, and committees of which he/she is a member, and hold office in the staff organization, in the department, section and committees of which he/she is a member.

c. **Responsibilities** - Each member of the active staff shall:

(1) Meet the basic requirements set forth in Section 3.3.
(2) Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.
(3) Actively participate in the quality/utilization management activities required of the staff; in monitoring new appointees of his/her same profession; in serving on Emergency Services on-call schedule, if eligible, except as exempted by the MSEC; and in discharging such other staff functions as may from time to time be required.
(4) Satisfy the requirements set forth in Article XII for attendance at meetings of the staff and of the department, section, and committees of which he/she is a member.
(5) Shall admit or render care to at least ten (10) patients each year.
(6) Apply for reappointment to the Medical Staff on a bi-annual basis and as part of the reappointment process to undergo a specific evaluation of the staff member's mental and physical capabilities.
(7) Serve on Medical Staff committees as a member or as chair of such committees.
(8) Participate in continuing medical education programs appropriate to their specialty.

4.3 Associate Staff

a. **Qualifications** - The associate staff is a provisional appointment and shall consist of practitioners who will be considered for advancement to the active staff after serving in an associate staff status for not less than one year, provided they meet the qualifications of the active staff as specified in Section 4.2a.

b. **Prerogatives** - The prerogatives of an associate staff member are:

(1) Admit and care for patients under the same conditions as specified in Section 4.2, for active staff members.
(2) Exercise such clinical privileges as are granted pursuant to Article VI.

c. **Responsibilities** –

(1) Meet the basic requirements set forth in Section 3.2
(2) Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the hospital for whom (s)he is providing services, or arrange a suitable alternative for such care and supervision.
(3) Actively participate in the quality/utilization management activities required of the staff; in monitoring new appointees of his/her same profession; in serving on Emergency Services on-call schedule, if eligible, except as exempted by the MSEC; and in discharging such other staff functions as may from time to time be required.
(4) Satisfy the requirements set forth in Article XII for attendance at meetings of the staff and of department, section, and committees of which he/she is a member.
(5) Shall admit or render care to at least ten (10) patients each year.
(6) To apply for reappointment to the Medical Staff on a bi-annual basis and as part of the reappointment process to undergo a specific evaluation of the staff member's mental and physical capabilities.
(7) Serve on committees as a voting member, but not hold office or serve as chair of any committee unless appointed by the Medical Staff President.
(8) Participate in continuing medical education programs appropriate to their specialty.

4.4 Courtesy Staff

a. **Qualifications** - The courtesy staff shall consist of practitioners who either (1) admit**,** register, or render care to not more than 10 patients per year, or who (2) as former active staff members no longer provide elective admissions/procedures, but who instead, provide infrequent coverage of a brief duration to patients of an active or associate staff peer. In the latter case above, the courtesy staff member must return the care of the patient to the active or associate staff member at the earliest possible time.

b. **Prerogatives** - The prerogatives of a courtesy staff member shall be to:

(1) Admit 0-10 patients per year as determined by the Credentials Committee, and care for patients under the same condition as specified for active staff members, if qualifying under 4.4(a)(1) above, or provide brief care if qualifying under 4.4(a)(2) above.

(2) Courtesy staff members qualifying under 4.4 (a)(1) may admit 0-10 patients per year as determined by the Credentials Committee.
(3) Except as necessary to cover the patients of an active or associate staff member, Courtesy staff members qualifying under 4.4(a)(2) shall not have admitting privileges.

c. **Responsibilities** - Each member of the courtesy staff shall:

(1) Retain responsibility within an area of professional competence for the care and supervision of each patient in the hospital for whom the practitioner is providing services or arrange a suitable alternative for such care and supervision; and
(2) Has their primary professional practice office within the proximate area of the medical center. (See "Definitions.")
(3) To apply for reappointment to the Medical Staff on a bi-annual basis and as part of the reappointment process to undergo a specific evaluation of the staff member's mental and physical capabilities.
(4) Attend general Medical Staff meetings.
(5) Participate in continuing medical education programs appropriate to their specialty.
(6) Courtesy staff members shall have no committee responsibilities, may not vote, and may not hold office.

4.5 Consulting Staff

a. **Qualifications** - The consulting staff shall consist of specialists who do not have their primary professional practice office in the proximate area and have areas of specialties and expertise needed at the medical center but not available within the proximate area. These specialists are appointed for the specific purpose of providing, either in person or by means of electronic telecommunication tools, consultation, diagnosis, and treatment of patients, and the administration of clinical departments.

b. **Prerogatives** - The prerogatives of a consulting staff member shall consist of:

(1) Provide medical consultation upon the request of an attending practitioner.
(2) Exercise such clinical privileges as are granted to the physician.
(3) Attend general Medical Staff and department meetings.
(4) Consulting physicians may not vote, hold office, or serve on Medical Staff committees.

c. **Responsibilities** - Each member of the consulting staff shall assume responsibility within his/her area of professional competence for the care and supervision of each patient in the hospital for whom he/she is providing services or arrange a suitable alternative for such care and supervision.

4.6 Honorary Staff

a. **Qualifications** - The honorary staff shall consist of practitioners who have retired from active hospital practice after long-standing service to the hospital or outstanding reputation; or shall consist of non-appointees who are of outstanding reputation not necessarily residing in the community.

b. **Prerogatives** - Persons appointed to the honorary staff shall not be eligible to admit or care for patients, to vote, to hold office, or to serve on standing Medical Staff committees unless an exemption is specifically approved by the Board; but may be appointed to special committees or projects. Honorary staff, may, but are not required to attend any Medical Staff meeting.

4.8 Affiliate Staff

a. **Qualifications** – The affiliate staff shall consist of practitioners who do not practice in the Medical Center's primary service area and who refer patients to other members of the Medical Center's medical staff, but who wish to follow the progress of their referred patients.

b. **Prerogatives** – The prerogatives of an affiliate staff member shall consist of:

(1) Visiting their referred patient while in the hospital.
(2) Writing suggestions (not orders) in the patient's progress notes.
(3) Receiving copies of the patient's discharge summary, pertinent lab work and radiology reports.
(4) Attending medical staff meetings and functions at the Medical Center.
(5) Receiving literature and CME opportunities offered to other staff members.

4.9 Limitations of Prerogatives

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a physician's or dentist's staff appointment, by other articles in these Bylaws, or by other policies of the medical center.

ARTICLE V
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 General Procedure

The Medical Staff, with assistance of the executive staff, through its designated departments, sections, committees, and officers, shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit evaluations and/or recommendations to the Board. The Medical Staff exercises the same consideration with respect to the review of specified professional personnel applications whether or not such individuals are eligible for Medical Staff appointment. Neither the staff nor its committees are empowered to make any final decisions respecting appointments or privileges. Such decisions are the sole responsibility of the Board.

5.2 Application for Initial Appointment

a. **Application Form -** Each application for appointment to the Medical Staff shall be in writing, on a form prescribed by the Board, and signed by the applicant. All written requests for application forms from practitioners shall be filled promptly by the President/CEO, and a copy of the Bylaws, Rules and Regulations shall be furnished to each applicant.

b. **Content -** The application form shall provide for such provisions as are necessary to secure information useful for evaluation of the applicant and evidence of professional qualification. It shall be deemed complete when it includes at a minimum, information pertaining to:

(1) current licensure and/or certification, as appropriate, verified with the primary source or from a credentials verification organization (CVO)
(2) relevant education
(3) training and/or experience, verified with the primary source or from a CVO
(4) peer review and recommendations
(5) challenges to any licensure, registration, or health care facility membership, appointment or clinical privileges
(6) voluntary or involuntary discipline or relinquishment of any license or registration
(7) voluntary or involuntary termination of medical staff membership or appointment to another hospital or healthcare facility
(8) voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or healthcare facility
(9) professional liability
(10) current competence, including data from professional practice review by an organization that currently privileges the applicant, if available, and morbidity/mortality data, when available. Data from primary sources or from a CVO is preferred when feasible.
(11) evidence of the applicant's physical ability to carry out the privileges requested
(12) consent and authorization for any person or organization referenced in the application to provide independent verification
(13) consent of the applicant to an interview, if requested, by any officer of the Medical Staff or member of the Board
(14) a delineation of privileges desired

(15) National Practitioner Data Bank
(16) criminal background check
(17) eligibility to participate in government payment programs
(18) Drug Enforcement Administration certificate/Bureau of Narcotics and Dangerous Drugs certificate if appropriate for specialty
(19) tuberculosis exposure status
(20) current photograph issued by a government agency i.e. driver's license, passport photo
(21) National Provider Identifier
(22) any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant

In addition, the form shall include a statement that the applicant has been furnished a copy of the Bylaws, Rules and Regulations, and that the applicant agrees to be bound by the terms thereof during the time the application is under consideration and, if staff appointment is granted, while a member of the staff.

5.3 Effect of Application

By applying for appointment to the staff, the applicant:

a. Signifies his/her willingness to appear for interviews in regard to his/her application.

b. Authorizes Medical Center representatives to consult with others who have been associated with the applicant and/or who may have information bearing on his/her competence and qualifications.

c. Consents to the inspection by medical center representatives of all records and documents that may be material to an evaluation of the applicant's personal and professional qualifications and ability to carry out the clinical privileges requested, as well as the applicant's ethical qualifications for staff membership.

d. Releases from any liability to all medical center representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials.

e. Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to medical center representatives in good faith and without malice concerning the applicant's ability, emotional stability, and other qualifications for staff appointment and clinical privileges.

f. Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a medical center representative, or against a medical center representative, shall be brought in a court, federal or state, in the state which the defendant resides or is located.

g. Certifies that statements are true and complete.

For purposes of this section, the term "medical center representative(s)" includes the Board, its members and committees, the President/CEO, the Medical Staff organization, all Medical Staff

members, departments, and committees which have responsibility for collection or evaluating the applicant's credentials or acting upon his/her applications, and any authorized representative of any of the foregoing.

5.4 Processing the Application

a. **Applicant's Burden** - The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, professional ethics, background, training, demonstrated ability, and, upon request of the MSEC or of the Board, physical and mental status, and of resolving any doubts about these or any of the other basic qualifications.

b. **Verification of Information** - The applicant shall deliver his/her application form to the President/CEO who shall, after determining that the application is complete, seek to collect pertinent materials and verify all required information. The President/CEO shall promptly notify the applicant of any failures in such collection or verification efforts. When all information has been collected and verified, the President/CEO shall forward within thirty (30) days, a copy of the completed application form and all supporting materials, as may be appropriate, to the chair of each department and/or section in which the applicant seeks privileges, and a copy of the completed application form and all supporting materials to the Credentials Committee.

c. **Departmental and Sectional Action** - Each department and/or section chair in which the applicant seeks privileges shall promptly review the application, the supporting documentation, and such other information available to them that may be relevant to consideration of the applicant's qualifications for the staff category, department and service affiliation, and clinical privileges requested. Within thirty (30) days of receiving the completed application, the department or section chair shall forward to the Credentials Committee a written report and evaluation as to staff appointment and, if appropriate, department or section affiliations, clinical privileges to be granted, and any special conditions to be attached to the appointment. If a report is adverse to an applicant, the reason for such report shall be stated and supported by reference to the completed application and all other documentation considered by the chair, all of which shall be forwarded with the report.

d. **Credentials Committee Action** - Upon receipt of the completed application form, the Credentials Committee shall insure that verification of the applicant's references, licensure, DEA status, and other pertinent information has occurred. The committee may elect to conduct an interview of the applicant to which the chair of each department and/or section in which the applicant seeks privileges, shall be invited to attend and participate.

The Credentials Committee shall consider the report of the department chair and such other relevant information as is available to the committee. The committee shall, within sixty (60) days of receiving the verified application, forward to the MSEC and President/CEO, its written report and evaluation of the applicant. If the report supports the appointment, it shall include the recommended staff category, department and section affiliations, clinical privileges to be granted, and any special conditions to be attached to appointment. The Credentials Committee may also defer action on any particular privilege requested in the application. The reason(s) for each proposed action shall be stated and supported by reference to the completed application and all other

documentation considered by the committee, all of which shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

e. **MSEC Action** - At its next regular meeting after reviewing the Credentials Committee report, the MSEC shall consider the Credentials Committee report.

The committee may elect to act on the available information or may choose to interview the applicant. The committee, within forty-five (45) days, shall forward to the President/CEO for transmittal to the Board, a written report and recommendations in conjunction with Section 5.4(f), and if appointment is recommended, as to staff category, clinical privileges to be granted and any special considerations to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated and supported by documentation considered by the committee. Any minority views shall also be transmitted along with supportive references or reasons to the Board.

f. **Effect of MSEC Action** - The effect of the MSEC action shall be as follows:

(1) Deferral: Action by the MSEC to defer the application for further consideration must, within forty-five (45) days, be followed by a subsequent recommendation for appointment with specified clinical privileges, or for rejection of staff appointment.

(2) Favorable Recommendation: When the recommendation of the MSEC is favorable to the applicant, the President/CEO shall promptly forward the recommendation, together with the written report on the applicant to the Board.

(3) Adverse Recommendation: When the recommendation of the MSEC is adverse to the applicant, the President/CEO shall so inform the applicant within five (5) days by special notice, and he/she shall be entitled to the procedural rights as provided in Article VIII. *(For the purposes of Section 5.4, an "adverse recommendation" by the MSEC is as defined in Section 8.3(b) of Article VIII, except that in the circumstance in which the applicant accepts the limitation, reduction, or denial which other-wise is deemed adverse, such acceptance converts the adverse recommendation to a favorable one.)*

g. **Board Action** -

(1) Favorable MSEC Recommendation: At its next regular meeting, except for good cause, following receipt of the MSEC's report & recommendation, the Board shall act on the applicant's application. The Board shall adopt or reject, in whole or in part, a favorable recommendation of the MSEC, or refer the recommendation back to the MSEC for further consideration stating the reasons for such referral back, and setting a time limit within which a subsequent recommendation shall be made, if necessary. If the Board's action is adverse to the applicant as defined in Article VIII, Section 3, the President/CEO shall so inform the applicant within five (5) days by special notice, and he/she shall be entitled to certain procedural rights pursuant to the fair hearing plan as provided in Article VIII.

(2) Without Benefit of MSEC's Recommendations: If the Board does not receive a MSEC recommendation within the time period prescribed by these Bylaws, then the Board may take action on its own initiative, if the applicant so requests. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse as defined in Article VIII Section 8.3(b), the President/CEO shall so inform the applicant within five (5) days by special notice, and he/she shall be entitled to procedural rights as provided in Article VIII.

(3) After Procedural Rights: In the case of an adverse MSEC recommendation pursuant to Section 5.4(f)(3) or an action pursuant to Section 5.4(g)(2) of this Article, the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article VIII. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer its final determination by referring the matter back to the MSEC for further consideration. Any such referral back shall state the reasons, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the staff or to reject him/her for staff membership.

(4) Denial for Hospital's Inability to Accommodate Applicant - A recommendation by the MSEC or a decision by the Board to deny staff appointment, a department, service, or staff category assignment, or particular clinical privileges may include:

(a) the basis of the hospital's present inability, as supported by documented evidence, to provide adequate facilities or supportive services for the applicant and his/her patients; or
(b) the basis that there is no need as supported by documented evidence for additional staff appointees with the skill and training of the applicant; or
(c) the basis of inconsistency with the hospital's written plan of development, including the mix of patient care services to be provided, as currently being implemented.

If staff appointment, a department, service, or staff category assignment or particular clinical privileges are denied pursuant to (a)(b)(c) above, the notice of the final decision shall not entitle the applicant to the procedural rights as provided in Article VIII. If the Board agrees with the MSEC, the notice of final decision shall state that upon written request by the applicant to the President/ CEO, the application will be kept in a pending status for the next succeeding two (2) years. If during this period the hospital finds it possible to accept staff applications for which the applicant is eligible, and the hospital has no obligation to applicants with prior pending status, the President/ CEO shall promptly inform the applicant by special notice. Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided for initial appointments shall apply.

(5) Notice of Final Decision

(a) Notice of the Board's final decision shall be given to the Medical Staff President and the chair of each department concerned, and to the applicant by means of special notice.

(b) A decision and notice to appoint shall include:
i. the staff category to which the applicant is appointed;
ii. the department and section to which he/she is assigned;
iii. the clinical privileges he/she may exercise; and
iv. any special conditions attached to the appointment.

5.5 Reappointment Process

a. **Reappointment Application Form** - The President/CEO, at least ninety (90) days prior to the expiration date of the present staff appointment of each staff member, shall provide such member with an interval information form prescribed by the Board for use in considering reappointment. Each staff member who desires reappointment shall, within thirty (30) days of receipt of the reappointment form, return the form to the President/CEO. Failure, without good cause, to so return the form shall constitute a voluntary relinquishment of his/her membership/privileges at the end of the current term, without entitlement to the procedural rights provided in Article VIII.

b. **Verification of Information** - The President/CEO, within thirty (30) days of receipt, shall forward the reappointment application form to the Credentials Committee. The Credentials Committee shall insure that the verification has occurred and will collect any other materials or information deemed pertinent, including information regarding the staff member's current licensure; documentation of health status; professional activities; challenges to any licensure, registration or health care facility membership, appointment or clinical privileges since the last application; voluntary or involuntary termination of Medical Staff membership since the last application; voluntary or involuntary discipline or relinquishment of any license or registration since the last application; voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital since the last application; National Practitioner Data Bank report; eligibility to participate in government payment programs; DEA/BNDD certificates (if applicable); current tuberculosis exposure status; any evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant; relevant practitioner specific data as compared to the aggregate (when available); and morbidity and mortality data (when available). The committee shall also review the following since the last application: the practitioner's performance within the hospital; judgment, clinical, and/or technical skills; conduct in the hospital; peer review recommendation; a recommendation from the department to which the staff member is assigned or any other reasonable indicators of continuing qualifications. Possession of a current State of Missouri professional license shall fulfill the continuing medical education requirements. The Credentials Committee, after reviewing each interval information form and all other relevant information available to it, shall forward to the MSEC and to the President/CEO for the MSEC's recommendation to the Board, its report and recommendation that appointment be either renewed, renewed with modified staff category, department, section affiliation and/or clinical privileges, or terminated. The committee may also defer action. Each such report shall satisfy the requirements of Section 5(d) of this Article.

c. **Processing** - The procedure provided in Sections 5.4 of this Article shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read respectively as "staff member" and "reappointment."

d. **Bases for Recommendation** - The recommendation of the MSEC concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon evaluation of such member's professional ability, including the member's ongoing professional practice data and the focused practitioner review (if any); his/her clinical judgment in the treatment of patients; his/her professional ethics; his/her discharge of staff obligations; his/her compliance with these Bylaws, Rules and Regulations and all other established standards, policies, and rules of the medical center; his/her cooperation with other practitioners, medical center personnel and with patients; his/her effective and efficient use of the medical center; his/her participation in educational programs; his/her health status; his/her malpractice insurance; and other matters bearing on his/her ability and willingness to contribute to good patient care practices at the medical center.

e. **Time Periods for Processing** - Transmittal of the reappointment application form to a staff member and his/her return of it shall be carried out in accordance with Section 5.5a of this Article. Thereafter, except for good cause, all actions by the MSEC and the Board shall be completed prior to the expiration date of the staff membership of the staff member being considered for reappointment.

5.6 Requests for Modification of Terms of Appointment

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, department and/or section assignment, or clinical privileges by submitting a written application to the President/CEO on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 5.5 of this Article for reappointment.

5.7 Board Applied Criteria

The Board shall apply, in making its decisions in respect to appointment, reappointment, clinical privileges, and modification of appointment, the criteria stated in these Bylaws and, in addition, shall consider the adequacy of the medical center's facilities and supportive services, the need for practitioners with skill and qualifications of the applicant and the hospital's plan of development.

5.8 Reapplication After Adverse Decision

A practitioner seeking appointment or reappointment, who has received a final adverse decision resulting in failure to be appointed or reappointed, shall not be eligible to reapply to the staff for a period of two (2) years, unless the decision provides otherwise. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

ARTICLE VI
DETERMINATION OF CLINICAL PRIVILEGES

6.1 Exercise of Privileges

Every staff member or specified professional personnel providing direct clinical services at the hospital by virtue of staff membership or otherwise, in connection with such practice and except as provided in Sections 6.4 and 6.5 of this Article, shall be entitled to exercise only those clinical privileges or provide patient care services as are specifically granted pursuant to the provisions of these Bylaws and the staff rules and regulations.

All grants of clinical privileges shall be subject to the provisions of the policy of exclusivity as may be adopted by the Board and any adverse policy of exclusivity shall not give rise to any right to a hearing or appellate review provided in these Bylaws, including those provided in Article VIII.

6.2 Delineation of Privileges

a. **Requests** - Each application for appointment and reappointment to the Medical Staff must contain a request for the clinical privileges desired by the applicant. A request for clinical privileges by a staff member pursuant to Article V Section 5.6 must be supported by documentation of training and/or experience supportive of the request. Physicians requesting privileges must apply for core privileges for that specialty. Physicians will not be permitted to resign privileges that are included in the core for their specialty. Physicians will be expected to maintain sufficient competence for all privileges within the core. If a staff member is unable to maintain competence in the full core privileges, he/she is required to make coverage arrangements with another staff member to care for patients requiring care within that core.

b. **Bases for Privilege Determination** - Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgment. The bases for privileges determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the quality improvement/utilization management activities required by these and the medical center's Corporate Bylaws to be conducted at the medical center. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources including, but not limited to, other health care facilities where a practitioner exercises clinical privileges. This information shall be added to and maintained in the staff file established for a staff member.

c. **Surgical Privileges** -

(1) A physician applicant for staff appointment seeking surgical privileges must have completed the number of years of residency with substantial surgical component, approved by the Accreditation Council for Graduate Medical Education or the Committee on Postdoctoral Training of the American Osteopathic Association,

sufficient to satisfy the specialty board requirements for eligibility to become certified, in effect at the date application for staff appointment is submitted.

(2) A dentist applicant for staff appointment seeking oral surgery privileges must have completed the number of years of residency in an oral surgery residency program approved by the American Dental Association Commission on Dental Accreditation sufficient to satisfy the specialty board requirements for eligibility to become certified; in effect at the date application for staff appointment is submitted.

(3) A podiatrist applicant for staff appointment seeking podiatric surgical privileges shall be board certified in foot and ankle surgery by the American Board of Podiatric Surgery or shall have completed a twenty-four month residency in podiatric surgery, which residency is approved by the American Board of Podiatric Surgery.

(4) The residency requirements in Paragraphs 1 and 2 above do not apply to practitioners with staff appointments on the date these Bylaws become effective.

(5) The above are not intended to preclude the development of a mechanism for credentialing practitioners to perform new technologies.

d. **Procedures** - All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article V.

6.3 Specified Professional Personnel

Members of the Medical Staff may recommend to the Board the granting of clinical privileges to specified professional personnel, based upon investigation and evaluation of the education, training, experience and demonstrated ability and judgment of individuals requesting privileges as specified professional personnel, following the process and procedures of Articles 5 and 6 of these Bylaws. A recommendation by or on behalf of the Medical Staff to not grant privileges to an applicant for privileges as a specified professional personnel, or to suspend, terminate, or discontinue such privileges, or such a decision by the Board, shall give rise to the procedural rights set forth in Article VIII. The Administrative Policies, SPP-Advanced Practice Nurses and SPP Certified Physician Assistants exist to guide the privileging of specified professional personnel.

6.4 Temporary Privileges

a. **Circumstances** - Upon the recommendation of either the clinical department chairperson or the Medical Staff President , the President/CEO or authorized designee may grant temporary privileges in the following circumstances:

(1) Pendency of Application: After receipt of an application for staff appointment, including a timely request for specific temporary privileges and in accordance with the conditions specified in Article VI, Section 6.4(b), an appropriately licensed applicant may be granted temporary privileges during the pendency of the application not to exceed 120 days. In exercising such privileges, the applicant shall act subject to the direction of the chair of the department to which he/she is assigned.

(2) Patient Care Need: After submission of an application and verification of the applicant's current license and clinical competence and upon recommendation of either the applicable clinical department chairperson or the Medical Staff

President, the President/CEO may, on a case-by-case basis, when there is an important patient care need that mandates immediate authorization to practice, grant temporary privileges to a practitioner.

b. **Conditions** - Temporary privileges shall be granted under Article VI, Section 6.4a(1)only between the time "after" an application is deemed "complete" (following review and a favorable recommendation documented by the appropriate Section/Department Chairperson[s], and recommended for approval by the Credentials Committee) and such time that the application is acted upon by the Board of Directors. For purposes of temporary privileges, an application will be deemed complete when all of the information required by Article V, Section 5.2 of these Bylaws has been submitted and verified as described in Article V, Section 5.4 and the report of the National Practitioner Data Bank has been received and evaluated. Temporary privileges shall not be granted in any case where the applicant has (i) a current or previously successful challenge to a license or registration or (ii) has been subject to involuntary limitations, reductions, denial or loss of clinical privileges at another facility. The practitioner must provide evidence of professional liability insurance coverage, as required by the Board or other evidence of financial responsibility satisfactory to the Board. All applications must be received a minimum of ninety (90) days prior to the date on which the practitioner expects to begin practicing. Exceptions will be considered on an individual basis. Special requirements of consultation and reporting may be imposed by the chair of the department for a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge that he/she has received and read the Medical Staff Bylaws, Rules and Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges, unless otherwise allowed by the individual granting the privileges.

c. **Termination** - On the discovery of any information, or the occurrence of any event of a professionally questionable nature pertinent to a practitioner's qualifications, or where the ability to exercise any or all of the temporary privileges granted may endanger the life or well-being of a patient by continued treatment by a practitioner, the President/CEO, after consultation with the chair of the department responsible for supervision, the Medical Staff President or any person so authorized under Article VII Section 7.1(a), may terminate any or all of such practitioner's temporary privileges. In the event of any such termination, the practitioner's patients then in the medical center shall be assigned to another practitioner by the Medical Staff President or in his/her absence any elected member of the MSEC. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The terminated practitioner shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

d. **Rights of the Practitioner** - A practitioner shall not be entitled to the procedural rights afforded by Article VIII because of his/her inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

6.5 Emergency Privileges

For the purposes of this section, an "emergency" is defined as 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. In the case of an emergency, any practitioner, to the degree permitted by his/her license, regardless of department, staff status, or clinical privileges, shall be permitted to do, and shall be assisted by

medical center personnel in doing everything possible to save the life of a patient or to save a patient from serious harm.

A practitioner utilizing emergency privileges, if requested by the President/CEO or Medical Staff President, shall provide to the MSEC and the President/CEO a statement explaining the circumstances giving rise to the emergency.

6.6 Disaster Privileges

A disaster will be defined as an unanticipated event placing the medical services of a hospital or community in the position to receive a sudden influx of excess patients in urgent need of treatment at a greater rate than the system can normally absorb. In the event of a disaster situation as declared by local emergency officials and the President/CEO or his/her designee, physicians and Specified Professional Personnel may undergo immediate credentialing according to the *Credentialing Physicians and Specified Professional Personnel in a Disaster* policy. The authority to grant temporary disaster privileges has been delegated by the Board to the President/CEO or designee, Vice President of Medical Affairs, Medical Staff President or Department Chair of the practitioner's specialty.

6.7 Histories and Physicals

The admitting or attending practitioner is responsible for documenting the initial history and physical report and the discharge summary. If granted privileges to do so, specified professional personnel may perform a patient's history and physical provided the admitting or attending physician, must, consistent with Medical Center policy, confirm and endorse in writing the findings, conclusions and assessment of risk prior to diagnostic or therapeutic interventions.

a. A complete admission History and Physical examination shall be dictated and placed in the medical record within twenty-four (24) hours of admission but prior to surgery or a procedure requiring anesthesia services.

b. Office History and Physical – A History and Physical initiated and legibly recorded by a member of the medical staff within thirty (30) days of admission and updated with all of the information listed in Section 3.14(b) of the Medical Staff Rules and Regulations may be used in the patient's hospital record. In such instances, the H&P must be completed by updating the record with all additions and/or changes to the initial H&P within 24 hours of admission but prior to surgery or a procedure requiring anesthesia services.

Additional requirements for documenting medical histories and physical examinations, including appropriate H&P content, can be found in Article III (3.14) of the Saint Francis Medical Center Medical Staff Rules and Regulations.

ARTICLE VII
CORRECTIVE ACTION

7.1 Routine Corrective Action

a. **Criteria for Initiation** - Whenever the activities or professional conduct of any staff member are believed to undermine the culture of safety, or are believed to be detrimental to patient safety or quality patient care, or are reasonably probable of being disruptive to medical center operations, or

are reasonably probable of being in violation of the Bylaws, Rules and Regulations, departmental rules, or other medical center policies, or when the practitioner exhibits signs of physical or mental impairment, corrective action against such staff member may be initiated by the chair of any department or standing committee of the staff, by an officer of the MSEC, by the President/CEO, or the Board. If the staff member's conduct is believed to be due to alcohol, drug or other substance abuse, or other physical or mental condition, action shall first be pursued under the Medical Center's policy entitled *Intervention for Impaired Medical Staff Members or Specified Professional Personnel.* If the practitioner refuses to cooperate under the policy or if it is not successful in correcting the practitioner's conduct, then corrective action under this Article should be pursued. Initiation of corrective action pursuant to this section does not preclude imposition of suspension as provided for in Section 7.2(a), nor does it require the prior imposition of such a suspension. The provisions of this Article VII shall also apply to specified professional personnel credentialed under Article VI, Section 6.3.

b. **Requests and Notices** - All requests for corrective action shall be submitted to the Medical Staff Peer Review Committee. The Peer Review Committee shall evaluate the request according to procedures described in Article 12.4.a.

c. **Investigation** - An investigation will be considered to have started upon MSEC receipt of a report from the Peer Review Committee (See *Code of Conduct* policy).

d. **MSEC Action** - Within thirty (30) days or at its next scheduled meeting following receipt of the report from the Peer Review Committee, the MSEC shall take action on the request. Such action may include, without limitation:

(1) Rejecting the request for corrective action;
(2) Issuing a warning, a letter of admonition or a letter of reprimand;
(3) Recommending terms of probation or requirements of consultation;
(4) Recommending reduction, suspension, or revocation of clinical privileges;
(5) Recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care; and
(6) Recommending suspension or revocation of staff appointment.

e. **President/CEO's Option** - When the MSEC has rejected a request for corrective action, it shall forward to the President/CEO a copy of the report as set forth in Section 7.1(c) of this Article**.** The President/CEO may either, (i) accept the MSEC's decision, (ii) appoint an ad hoc investigating committee, or, (iii) direct the appropriate department chair to appoint an investigating committee, to investigate further the activities or conduct, and to submit a written report of the investigation to him/her. Such report may be submitted by the President/CEO to the MSEC for action in accordance with Section 7.1(d) of this Article.

f. **Board Option** - When the MSEC, after review of a report of investigation, or after review of summary suspension imposed pursuant to Section 7.2 of this Article, determines that no corrective action be taken, the President/CEO shall report such determination to the Board. The Board, in its discretion, may agree with the MSEC**,** or appoint a committee to conduct an investigation of the conduct that served as the basis for the request for corrective action and, after receipt of the report of the investigation, take any such action as is set forth in Section 7.1(d) of this Article.

g. **Procedural Rights** - Any action by the MSEC pursuant to Sections 7.1(d)(3-6) of this Article, or any combination of such actions, or action by the Board pursuant to Section 7.1(f) to impose corrective action as defined in Section 7.1(d)(3-6) shall entitle the staff member to the procedural rights as provided in Article VIII.

7.2 Summary Suspension (Interim Revocation of Privileges)

a. **Criteria and Initiation** - Whenever**,** in the opinion of the President/CEO or MSEC, a staff member willfully disregards or grossly violates the Bylaws, Rules and Regulations, or other medical center policies, or whenever his/her conduct requires that prompt action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other persons present in the medical center, or whenever the conduct of the staff member materially disrupts the operations of any department of the medical center, the President/CEO or the MSEC, in consultation with the other, shall have the authority to suspend the staff appointment, or reduce any or all of the clinical privileges of such staff member. Such action on privileges of an affected member shall become effective immediately upon imposition, and the President/CEO shall promptly give special notice of the suspension to the staff member, and notice to the MSEC of such action.

b. **MSEC Action -** As soon as reasonably possible but no later than 14 days after the imposition of the suspension, or earlier if an accelerated review is requested in writing by the suspended staff member, the MSEC shall be convened to review and consider the appropriateness of action taken. The MSEC shall recommend to the Board modification, continuation, or termination of the terms of the suspension.

c. **Procedural Rights** - Unless the MSEC recommends immediate termination of the suspension and cessation of all further corrective action, the staff member shall be entitled to the procedural rights as provided in Article VIII. The terms of the suspension as sustained by the MSEC shall remain in effect pending a final decision by the Board. If the Board, upon recommendation of the MSEC, and after such review, decides to continue the suspension, the staff member shall be entitled to the procedural rights as provided in Article VIII.

7.3 Suspension and Revocation

a. **License -** If a staff member's license to practice his/her profession in the State of Missouri is revoked, suspended, or the licensing agency imposes terms of probation or limitation of practice on the practitioner, such staff member shall immediately and automatically be suspended or limited from practicing in the medical center, coincidental with the action taken by the state licensing board.

b. **Drug Enforcement Administration (DEA) Number** - A staff member whose DEA number is revoked or suspended or voluntarily relinquished shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. As soon as reasonably possible after such automatic suspension, the MSEC shall convene to review and consider the facts under which the DEA number was revoked or suspended. The MSEC may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation.

c. **Failure to Satisfy Special Appearance Requirement -** A staff member who fails to appear upon request of a department, section or committee pursuant to Article XIII Section 13.7(b) shall subject himself/herself to possible immediate and automatic suspension from exercising all or such portion of his/her clinical privileges in accordance with the provisions of Section 13.7(b).

d. **Conviction of a Felony** - Upon exhaustion of appeals after conviction of a felony or in certain cases after the filing of charges against a staff member in any court of the United States, either federal or state, which in the judgment of the MSEC or Board is deemed to be detrimental to the medical center or patient care, the member's staff appointment is automatically suspended or revoked.

e. **Procedural Rights** - A staff member whose appointment or privileges have been automatically suspended or revoked pursuant to Section 7.3(a) through (d), may request a hearing by a committee appointed by the Board to present evidence to establish that the automatic suspension or revocation

was invoked in error. The hearing and any subsequent proceedings shall be conducted in accordance with the provisions of Article VIII. The invoking of an automatic suspension does not preclude initiation of corrective action pursuant to Section 7.1 of this Article. Revocation pursuant to this section of the Bylaws does not preclude the staff member from subsequently applying for staff appointment.

7.4 Voluntary Relinquishment

a. **Medical Records** - Failure to adequately maintain and complete medical records within thirty (30) days of a patient's discharge as required by the Rules and Regulations and the medical center's policies pertaining to the completion of medical records shall be deemed a voluntary relinquishment of clinical privileges. This provision shall not apply in any case in which a delay or deficiency in maintaining records is attributable to the practitioner's illness or excusable absence or the act(s) of medical center employees.

b. **Loss of Insurance** - A staff member who loses or fails to maintain malpractice insurance, in accordance with the requirements established by the Board, shall have his/her admitting privileges immediately suspended and a special notice shall be issued to the practitioner stating that failure to acquire such insurance coverage within thirty (30) days shall constitute a voluntary resignation from the staff effective immediately.

c. **Exclusion from government payment programs** - A staff member who is suspended or excluded from government payment programs shall have his/her privileges immediately suspended pending review of the circumstances surrounding the suspension or exclusion by the Medical Staff Peer Review Committee.

d. **Conviction of a felony offense** - A staff member who is convicted of a felony offense shall have his/her privileges immediately suspended pending review of the circumstances surrounding the conviction by the Medical Staff Peer Review Committee.

e. **Procedural Rights** - A staff member under voluntary relinquishment or who has resigned by operation of Sections 7.4(a) or (b) of this Article, shall be entitled to the procedural rights provided in Article VIII, but only for the purpose of establishing justification for failure to comply with the requirements.

7.5 Continuity of Patient Care

a. **Suspension** - Upon the imposition of suspension or the occurrence of an automatic suspension, the Medical Staff President shall provide for alternative coverage for the patients of the affected staff member who are in the medical center. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The affected staff member shall not care for patients except to confer with the substitute practitioner to the extent necessary to safeguard the patient's well-being.

b. **Voluntary Relinquishment** -

(1) Staff members under voluntary relinquishment as a result of Section 7.4 (a) and (b) of this Article shall be authorized to continue to care for patients hospitalized at the time such action occurred, patients admitted while taking emergency call, and care for patients on whom hospitalization or procedures had been previously scheduled prior to the voluntary relinquishment status.

(2) Staff members under voluntary relinquishment for failure to complete medical records shall also continue to take emergency calls.

ARTICLE VIII
FAIR HEARING PLAN

8.1 Definitions: Interviews, Hearings, and Appellate Review

a. **Interviews** - When the MSEC or the Board receives or is considering initiating an adverse recommendation concerning a staff member, the staff member may be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The staff member shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

b. **Hearings** - A committee appointed pursuant to Section 8.4(c) of this Article to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.

c. **Appellate Review** - A committee designated pursuant to Section 8.7(d) of this Article to hear a request for appellate review properly filed and pursued by a practitioner.

8.2 Hearings and Appellate Review Process

a. **Adverse MSEC Recommendation** - When any staff member receives special notice of an adverse recommendation or action of the MSEC as described in Section 8.3(a) or (b) of this Article, he/she shall be entitled, upon request, to a hearing before an ad hoc hearing committee. If the recommendation of the MSEC following such hearing is still adverse to the staff member, he/she shall then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

b. **Adverse Board Decision** - When any staff member receives special notice of an adverse decision by the Board taken either contrary to a favorable recommendation by the MSEC under circumstances where no right to a hearing existed, or on the Board's own initiative without benefit or a prior recommendation by the MSEC under circumstances where no right to a hearing existed, such staff member shall be entitled, upon request, to a hearing by an ad hoc hearing committee appointed by the Board. If such hearing does not result in a favorable recommendation, he/she shall then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

c. **Procedure and Process** - All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in this Article.

d. **Exceptions** - The denial, termination, or reduction of temporary privileges, or any other actions, except those specified in this Article, shall not give rise to any right to a hearing or appellate review.

8.3 Initiation of Fair Hearing

a. **Recommendations or Actions** - The following recommendations or actions shall, if deemed adverse pursuant to Section 8.3(b) of this Article, entitle the practitioner affected thereby to a hearing:

(1) Denial of staff appointment
(2) Denial of reappointment
(3) Suspension of staff appointment
(4) Revocation of staff appointment
(5) Denial of requested modifications of staff category
(6) Reduction of staff appointment
(7) Limitation of admitting prerogatives
(8) Denial of requested department assignment

(9) Denial of requested clinical privileges
(10) Reduction in clinical privileges
(11) Suspension of clinical privileges
(12) Revocation of clinical privileges
(13) Voluntary relinquishment of clinical privileges
(14) Terms of probation
(15) Requirement of consultation

b. **Conditions Constituting an Adverse Action** - A recommendation or action listed in Section 8.3(a) shall be deemed adverse only when it has been:

(1) Recommended by the MSEC; or

(2) Taken by the Board contrary to a favorable recommendation by the MSEC under circumstances where no prior right to a hearing existed; or

(3) Taken by the Board on its own initiative without benefit of a prior recommendation by the MSEC.

c. **Notification of Adverse Recommendation or Action in writing** - None of the actions described in Section 8.3a or 8.3b shall be taken and no recommendation for such action shall be made to the Board of Directors unless the member is first given special notice in writing of: (1) the proposed recommendation or action; (2) the reason for the proposed action or recommendation including the acts or omissions with which the member is charged; (3) the member's right to request a hearing provided said request is received within thirty (30) days of receipt of the special notice; and (4) that the hearing will be conducted in accordance with the provisions of these Medical Staff Bylaws and the member will have the right to (i) be represented by an attorney or other person of the member's choice; (ii) to have a record made of the proceedings; (iii) to call, examine, and cross-examine witnesses; (iv) to present relevant evidence regardless of admissibility in a court of law; and (v) to submit a written statement at the close of the hearing.

d. **Request for Hearing** - A practitioner shall have 30 days following receipt of notification pursuant to Section 8.3(c) to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the President/CEO, either in person or when sent by registered mail to the President/CEO, postage prepaid.

e. **Waiver by Failure to Request a Hearing** - The failure of a practitioner to request a hearing, to which the practitioner is entitled within thirty (30) days, waives any right to such hearing and to any appellate review to which the member might otherwise have been entitled. Such waiver in connection with:

(1) An adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.

(2) An adverse recommendation by the MSEC shall constitute acceptance of that recommendation which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the committee's recommendations at its next regular meeting following waiver by the practitioner. In its deliberations the Board shall review all the information and material considered by the committee and may consider all other relevant information received from any source in making its final decision.

The President/CEO shall promptly send the practitioner special notice informing him/her of each action pursuant to this paragraph (e), and shall notify the Medical Staff President of such action.

8.4 Fair Hearing Prerequisites

a. **Notice of Time and Place of Hearing** - Upon receipt of a timely request for hearing, the President/ CEO shall deliver such request to the Medical Staff President or to the Board, depending on whose recommendations or action prompted the request for hearing. The Medical Staff President or Board, as applicable, shall promptly appoint a Hearing Committee as set forth in Section 8.4c. Within ten (10) days of their appointment, the Hearing Committee shall request from the MSEC or the Board, as applicable, a list of witnesses, if any, expected to testify at the hearing on behalf of the MSEC or the Board. Upon receipt of the witness list, the Hearing Committee shall by special notice notify the member or applicant and the MSEC or the Board, as applicable, of the time, place and date of the hearing, which date shall not be less than thirty (30) days after the date of the Hearing Committee's notice. The special notice shall also enclose a copy of the MSEC's or Board's list of witnesses.

b. **Witnesses** - Within fifteen (15) days of receipt of the notice of the hearing, the member or applicant shall provide the Hearing Committee with a list of witnesses expected to testify at the hearing on behalf of the member or applicant.

c. **Appointment of Hearing Committee** -

a. By Medical Staff President - When a hearing relates to an adverse recommendation of the MSEC pursuant to Section 8.3(b)(1) of the Article, the Medical Staff President shall appoint a Hearing Committee comprised of at least three (3) members, but no more than seven (7) of the active Medical Staff. The committee shall choose a chair from among its members.

b. By the Board - When a hearing relates to an adverse decision of the Board that is contrary to the recommendation of the MSEC pursuant to Sections 8.3(b)(2) and 8.3(c) of this Article, the Chair of the Board shall appoint a hearing committee composed of at least five (5) persons. At least two (2) active Medical Staff members shall be included on this committee when the issues concern professional competence or performance. A chair shall be appointed from any one of the Hearing Committee appointees.

c. Eligibility for Hearing Committee - A Medical Staff or Board member who has participated in the initiation of the case shall not serve on the Hearing Committee nor shall any individual who is in direct economic competition with the member serve on the Hearing Committee. A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee because he/she has heard of the case or has a basic knowledge of the facts involved in the case. In any event, all members of a Hearing Committee shall be required to consider and decide the case with good faith objectivity.

8.5 Procedure

a. **Quorum** - There shall be at least a simple majority of the members of the Hearing Committee present when the hearing takes place. No member may vote by proxy. A Hearing Committee member who is not present at anytime during the testimony may not vote unless he/she reviews the transcript of the testimony.

b. **Record of Hearing** - A sufficiently accurate record of the hearing shall be kept to ensure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render an opinion or decision in the matter. The mechanism for recording the hearing shall be established by the Hearing Committee chair unless his/her decision is reversed by a majority vote of the Hearing Committee, and may be accomplished by court report, an electronic recording unit, detailed transcription, or minutes of the proceedings.

c. **Personal Appearance** - The personal appearance of the practitioner who requests the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing

shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Sections 8.3(e) of this Article.

d. **Postponement** - Requests for postponement of a hearing shall be granted by the Hearing Committee only upon showing of good cause.

e. **Presiding Officer** - Either a hearing officer, if one is appointed pursuant to Section 8.10(a) of this Article, or the chair of the Hearing Committee shall preside over the hearing to determine the order of procedure during the hearing, to maintain decorum and to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

f. **Representation** - The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the staff in good standing or by a member of the local professional society. The MSEC or Board, depending upon whose recommendation has prompted the hearing, shall appoint one of its members, or in the case of the MSEC, any staff member, to represent it at the hearing to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provisions in Section 8.10(b) of this Article.

g. **Rights of Parties - Subject to Section 8.5h below,** during a hearing, each of the parties shall have a right to:

(1) Call and ask questions of all witnesses;
(2) Introduce written statements, documents, or other exhibits; and
(3) Request that a record of the hearing be made by use of a court reporter or an electronic recording unit.

If the affected practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined.

h. **Procedure and Evidence** - The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely on the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents. The Hearing Committee shall permit the parties to submit a written statement at the close of the hearing.

i. **Evidentiary Notice** - In reaching a decision, the Hearing Committee may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Missouri. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record, to request that a matter be evidentially noticed and to refute the evidentially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee. The committee shall also be entitled to consider any pertinent material contained on file in the hospital, Bylaws, in connection with applications for appointment or reappointment to the staff, and for clinical privileges.

j. **Burden of Proof** - When a hearing relates to Sections 8.3(a)(1), (5), (8), or (9) of this Article, the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any factual basis or that such basis or the

conclusions drawn there from are either arbitrary, unreasonable, or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusions drawn there from are either arbitrary, unreasonable, or capricious.

k. **Recesses and Adjournment** - The Hearing Committee may recess the hearing and reconvene the same, without special notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

8.6 Hearing Committee Report and Further Action

a. **Hearing Committee Report** - Within thirty (30) days after final adjournment, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by the committee to the practitioner and the body whose adverse recommendations or action prompted the hearing.

b. **Action on Hearing Committee Report** - Within thirty (30) days after receipt of the report of the Hearing Committee, the MSEC or the Board, as the case may be, shall consider the same and shall affirm, modify, or reverse its recommendation or action in the matter and shall transmit its written result, together with the hearing record, the report of the Hearing Committee, and all other documentation considered to the President/CEO and the secretary/treasurer of the Medical Staff or Board, as appropriate.

c. **Notice and Effect of Result**

(1) Adopted by the Board - If the Board's result pursuant to Section 8.6(b) is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be closed. Prompt written notice of the Board's decision shall be forwarded to the practitioner from the President/CEO by certified mail with written notice also to the Medical Staff President.

(2) Adopted by the MSEC - If the MSEC's result pursuant to Section 8.6(b) is favorable to the practitioner, the President/CEO shall promptly forward it, together with all supporting documentation, to the practitioner and the Board for its final action. The Board shall take action thereon by adopting or rejecting the MSEC's result in whole or in part, or by referring the matter back to the MSEC for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The President/CEO shall promptly send the practitioner special notice by certified mail informing him/her of each action taken pursuant to this paragraph. Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed. If the Board's action is adverse in any of the respects listed in Section 8.3 of this Article, the special notice shall inform the practitioner of his/her right to request an appellate review by the Board as provided in Section 8.7 of this Article.

d. **Notice and Effect of Adverse Result** - If the result of the MSEC or of the Board pursuant to Section 8.6(b) or 8.6(c) of this Article continues to be adverse to the practitioner in any of the respects listed in Section 8.3(a), then prompt written notification of such adverse action shall be provided to the practitioner from the President/CEO by certified mail, return receipt requested. Such notification shall inform the practitioner of his/her right to request an appellate review by the Board as provided in Section 8.7 of this Article.

8.7 Initiation and Prerequisites of Appellate Review

a. **Request for Appellate Review** - A practitioner shall have fifteen (15) days following his/her receipt of a notice pursuant to Section 8.6(a)(c)(d) of this Article to file a written request for an appellate review. Such request shall be deemed to have been made when delivered to the President/CEO in person or when sent by registered mail to the President/CEO, postage paid, and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result. If such request is delivered in person, then a notarized, signed receipt must be provided.

b. **Waiver by Failure to Request Appellate Review** - A practitioner who fails to request an appellate review within the time and manner specified in Section 8.7(a) waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 8.3(a) of this Article.

c. **Notice of Time and Place of Appellate Review** - Upon receipt of a timely request for appellate review, the President/CEO shall deliver such request to the Board. The Board shall promptly schedule and arrange for an appellate review which shall be not less than fifteen (15) days nor more than sixty (60) days from the date of receipt of the appellate review requested, provided however that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than thirty (30) days from the date of receipt of the request for appellate review. At least fifteen (15) days prior to the appellate review, the President/CEO shall send the practitioner written notification by certified mail of the date, time, and place of the review. The time for the appellate review may be extended by the appellate review body for good cause.

d. **Appellate Review Body** - The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of five (5) members, at least four (4) of whom shall be members of the Board appointed by the chair. The committee shall choose a chair from among its members.

8.8 Appellate Review Procedure

a. **Nature of Proceedings** - The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, the committee's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section 8.8(b) of this Article and such other materials as may be presented and accepted under Section 8.8(d).

b. **Written Statements** - The practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the President/CEO at least ten (10) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the MSEC or by the board and, if submitted, the President/CEO shall provide a copy thereof to the practitioner at least three (3) days prior to the scheduled date of the appellate review.

c. **Presiding Officer** - The chair of the appellate review body shall be the presiding officer. The chair shall determine the order of the procedure during the review, maintain decorum, and make all required rulings.

d. **Oral Statement** - The appellate review body in its sole discretion may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing may be asked questions by any member of the appellate review body.

e. **New or Additional Matters** - New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

f. **Powers** - The appellate review body shall have all power granted to a Hearing Committee and such additional powers as are reasonably appropriate to discharge of its responsibilities.

g. **Recess and Adjournment** - The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

h. **Action Taken** - The appellate review body may recommend that the Board affirm, modify, or reverse the adverse result or action taken by the MSEC or by the Board pursuant to Sections 8.6(b) or (c) of this Article, or in its discretion may refer the matter back to the Hearing Committee for further review and recommendations to be returned to the appellate review body within thirty (30) days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board as provided in this paragraph.

i. **Conclusion** - 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.

8.9 Final Decision of the Board

a. **Board Action** - Within thirty (30) days after the conclusion of the appellate review board, or where permitted by the medical center's corporate bylaws, a committee of the Board duly authorized to act if so requested by the chair of the Board, shall render its final decision in the matter in writing and the President/CEO shall send written notice thereof to the practitioner by certified mail and written notice of the MSEC's last recommendation in the matter, if any. The Board's decision shall be immediately effective and final if the Board's action has the effect of changing the MSEC's last such recommendation. The Board shall refer the matter to the Joint Conference Committee. The Board's action on the matter following receipt of the Joint Conference Committee shall be immediately effective and final.

8.10 General Provisions

a. **Hearing Officer Appointment and Duties** - The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such officer shall be determined by the Board after consultation with the Medical Staff President. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/She shall act in an impartial manner as the presiding officer of the hearing. If requested by the Hearing Committee, he/she may participate in its deliberations and act as its legal advisor, but he/she shall not be entitled to vote.

b. **Attorneys -** If the practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance pursuant to Section 8.8(d) of this Article, he/she shall notify the Hearing Committee of the name and address of the attorney at least fifteen (15) days of receipt of the notice of hearing. If, and only if, the practitioner is represented by legal counsel shall the MSEC or the Board be allowed representation by an attorney. If the MSEC or Board is to be represented by counsel, it shall notify the Hearing Committee of the name and address of the attorney within fifteen (15) days of receipt of the applicant's or member's notice of attorney. The foregoing shall not be deemed to limit the practitioner, the MSEC, or the Board in the use of legal counsel in connection with the preparation for a hearing or appellate review. The role of the legal counsel shall be to advise physicians. They may not present to the Hearing Committee or question witnesses.

c. **Waiver -** If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this fair hearing plan, he/she shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under these Bylaws then in effect or under this fair hearing plan with respect to the matter involved.

d. **Number of Reviews -** Notwithstanding any other provision of these Bylaws or of the fair hearing plan, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

e. **Extension -** Stated time periods and limits for actions, notices, requests, submissions of material and scheduling in this Article may be extended upon the agreement of the parties and, when necessary, the Hearing Committee or appellate review body.

f. **Release -** By requesting a hearing or appellate review under the fair hearing plan, a practitioner agrees to be bound by the provisions of Article IX - Confidentiality, Immunity, and Release.

g. **Witness interviews -** All witness interviews shall take place at the hearing. The practitioner is not entitled to interview witnesses prior to the hearing (i.e. depositions).

8.11 Specified Professional Personnel. The provisions of this Article VIII shall apply to specified professional personnel credentialed under Article VI, Section 6.3

ARTICLE IX
CONFIDENTIALITY, IMMUNITY, AND RELEASE

9.1 Special Definitions - For the purposes of this Article, the following definitions shall apply:

a. **Information** - Records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 9.5(b) of this Article.

b. **Malice** - The dissemination of a known falsehood, or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement, or recommendation is warranted by the facts.

c. **Practitioner** - A staff member or applicant.

d. **Representative** - The Board and any member or committee thereof, the President/CEO, the staff organization and any member, office, department, section, or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

e. **Third Parties** - Both individuals and organizations providing information to any representative.

9.2 Authorizations and Conditions - By applying for, or exercising clinical privileges within this medical center, a practitioner:

a. Authorizes representatives of the medical center and the staff to solicit, provide, and act upon information bearing on his/her professional ability and other qualifications.

b. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and

c. Acknowledges that the provisions of this Article are express conditions to the application for, or acceptance of, staff membership, or the exercise of clinical privileges at the medical center.

9.3 Confidentiality of Information

Information with respect to any practitioner submitted, collected, or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative or the practitioner, or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general medical center records.

9.4 Immunity from Liability

a. **For Action Taken** - No representative of the medical center or staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement of recommendation made within the scope of his/her duties as a representative, if such representation acts in good faith and without malice. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

b. **For Providing Information** - No representatives of the medical center or staff and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing

information, including otherwise, privileged or confidential information, to a representative of this medical center or staff or to any other hospital, organization, or health professionals, or other health-related or educational institution or organization concerning a practitioner who is, or has been, an applicant to (or member of) the staff or who did or does exercise clinical privileges at this hospital, provided that such representative or third party acts in good faith and without malice.

9.5 Activities and Information Covered

a. **Activities** - The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

(1) Applications for appointment and clinical privileges;
(2) Periodic reappraisals for reappointment and clinical privileges;
(3) Corrective action;
(4) Hearings and appellate reviews;
(5) Quality assessment activities;
(6) Utilization reviews; and
(7) Other hospital, department, section committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

b. **Information** - The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to work cooperatively with others, economic efficiency, or any other matter directly or indirectly affecting patient care or the efficient functioning of an institution or organization.

9.6 Releases

Each practitioner shall, upon request of the medical center, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness as may be applicable under the laws of Missouri. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

9.7 Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE X
STAFF AND DEPARTMENT OFFICERS

10.1 Officers of the Staff

a. The officers of the staff shall be:
   (1) President
   (2) Vice President
   (3) Secretary

b. **Qualifications** - Officers must be members of the active staff in good standing, and shall have demonstrated ability as determined by Article VI Section 6.2(b) in at least one of the clinical departments at the time of nomination and election and must remain members in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The staff member is not eligible for election to an office he has held for two consecutive terms until a three (3) year period has passed.

c. **Nominations**

   (1) By Nominating Committee: The Nominating Committee shall submit to the secretary of the staff a list of one or more qualified nominees for each office forty-five (45) days prior to the annual meeting.
   (2) By Petition: Nominations may also be made by petition signed by at least fifteen percent (15%) of the members of the active staff with voting rights, to which is attached a statement signed by the nominee attesting to his/her willingness to stand for election to the office, and filed with the secretary at least thirty (30) days prior to the annual meeting. As soon after filing of a petition as is reasonably possible, the name(s) of this (these) additional nominee(s) shall be reported to the staff.
   (3) By Other Means: Only if, before the election, all of the individuals nominated for an office pursuant to Sections (c)(1) and (c)(2) above shall be disqualified from, or otherwise be unable to accept nomination, then the Nominating Committee shall submit one or more substitute nominees at the annual meeting, and nominations shall be accepted from the floor.

d. **Election** - Officers and committee members for whom election is required shall be announced at the annual meeting of the staff. Voting shall be by secret written ballot forwarded to each staff member prior to the annual meeting and returned at least one day prior to said meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a simple majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the event of a tie, the incumbent Medical Staff President shall cast the deciding vote.

e. **Term of Elected Office** - The term of office of elected officers shall be one (1) year, commencing on the first day of the Medical Staff year following the officers' election. The officers of the staff shall serve no more than two (2) consecutive terms of one year each. Each officer shall serve until the end of the term and until a successor is elected.

f. **Removal of Officers** - An officer shall be removed from office if a two-thirds (67%) majority of the active staff vote is in favor of removal, and provided that the MSEC and the Board concur. Grounds for removal shall include, but not be limited to, mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office. Action directed toward removing an officer from office may be initiated by submission to the MSEC of a petition seeking

removal of an officer, signed by not less than twenty-five percent (25%) of the members of the active staff with voting rights, or by a signed petition of the remaining members of the MSEC.

g. **Vacancies in Staff Offices** - Vacancies in office, other than that of Medical Staff President, shall be filled by the MSEC. If there is a vacancy in the office of Medical Staff President, the Vice President shall become Medical Staff President and serve out the remaining term.

h. **Duties of Elected Officers**

(1) Medical Staff President - The Medical Staff President shall serve as the principal elected official of the staff. As such, he/she will:

(a) Aid in coordinating the activities and concerns of the medical center administration and of the nursing and other patient care services with those of the Medical Staff.
(b) Be accountable to the Board, in conjunction with the MSEC, for the quality and efficiency of clinical services and performance within the medical center and for the effectiveness of the quality/utilization management program.
(c) Develop and implement, in cooperation with the department and committee chairs, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, and quality assessment.
(d) Appoint the staff representative and chairs to Medical Staff and medical center committees, unless otherwise expressly provided by these Bylaws or the Medical Center Bylaws, policies, or procedures.
(e) Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the President/CEO and to the Board.
(f) Be responsible for the enforcement of these Bylaws, and Medical Staff Rules and Regulations, for implementation of sanctions where these are indicated, and for the staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
(g) Call, preside at, and be responsible for the agenda of all general meetings of the staff.
(h) Serve as chair of the MSEC and as an ex-officio member of all other staff committees.
(i) Serve as the spokesperson of the staff in its external professional and public relations.
(j) Participate in the monthly Medical Center Board meetings.

(2) Vice President - The Vice President shall be a member of the MSEC. In the temporary absence of the Medical Staff President, the Vice President shall assume all the duties and have the authority of the President. The Vice President shall perform such additional duties as may be assigned by the Medical Staff President, the MSEC, or the Board.

(3) Secretary - The Secretary shall be a member of the MSEC and a staff member of the Joint Conference Committee. The duties shall be to:

a. Give proper notice of all staff meetings in order of the appropriate authority.
b. Prepare accurate and complete minutes for all meetings.
c. Perform such other duties as ordinarily pertain to the office.

10.2 Department and Section Officers

a. **Department Chairs**

(1) Qualifications - Each chair shall be a physician and remain a member in good standing of the active staff, shall be board certified or deemed equivalently competent in at least one of the clinical areas covered by the department and shall be willing and able to faithfully discharge the functions of his/her office.

(2) Appointment - At least thirty (30) days prior to the end of the Medical Staff year, the Medical Staff President for the incoming year shall recommend a staff member from each department who meets the qualifications of Section 2(a)(1) to serve as department chair, and forward the names of the nominees to the Board and the President/CEO for approval. The Board shall either appoint the nominee of the department or notify the Medical Staff President that it will not accept the candidate, and request another nominee.

(3) Terms of Office - A department chair shall serve until a successor is appointed. Removal of a department chair from office may be made by the Board acting upon its own recommendation or acting upon the recommendation of the President/CEO; or a two-thirds (67%) majority vote of the department members with active staff appointments.

(4) Vacancy - Upon a vacancy in the office of department chair, the Medical Staff President shall serve as department chair until a successor is appointed.

(5) Duties/Responsibilities - Each chair shall:

(a) Account to the MSEC for all professional, administrative, and quality review functions within the department.
(b) Assume responsibility for the review of quality and appropriateness of patient care for patients within the chair's respective department. Review shall be ongoing, planned, and systematic.
(c) Develop and implement departmental programs, in cooperation with the Medical Staff President and consistent with other provisions of these Bylaws, for credentials review and privileges delineation, continuing medical education, and quality/utilization management.
(d) Serve as a member of the MSEC, if provided for in Article XII Section 3(a), give guidance on the overall medical policies of the medical center, and make specific recommendations and suggestions regarding the department.
(e) Oversee continuing surveillance of the professional performance of all practitioners with clinical privileges and of all specified professional personnel with privileges in the department, assuring that the quality and appropriateness of patient care provided within the department are monitored, evaluated, and reported as appropriate, thereon to the MSEC.
(f) Forward to the appropriate authorities the department's recommendation concerning appointment and category, reappointment, criteria for clinical privileges, delineation of clinical privileges, and corrective action with respect to applicants to, and staff members of, his/her department as required.
(g) Appoint such committees as are necessary to conduct the functions of the department and designate a chair and secretary for each.
(h) Develop, implement, and enforce the Medical Center's policies that guide and support the provision of care, treatment, and services.
(i) Participate in all phases of administration of the department through cooperation with Patient Care Services and the executive staff in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.
(j) Assess the scope of services related to the care customarily provided by members of the department and determine the necessity of arranging for the provision of

services by external providers. If the services of external providers are required, the quality of those services is evaluated in terms of the standards established for the overall quality of care provided by the medical center.

(k) Assist in preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the MSEC, the President/CEO, or the Board.

(l) Act as presiding officer at all department meetings.

(m) Establish, together with members of the Medical Staff and administration, the type and scope of services required to meet the needs of patients and the medical center including recommendations regarding space and other resources needed by the department or service.

(n) Assist in the orientation and continuing education of all members of the department or service.

(o) Perform such duties commensurate with the office as may from time to time be reasonably requested of him/her by the Medical Staff President, the MSEC, the President/CEO, or the Board.

(p) Ensure the integration of the department or service into the primary functions of the hospital.

(q) Facilitate the coordination and integration of interdepartmental and intradepartmental services.

(r) Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

(s) Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, or services.

(t) Ensure continuous assessment and improvement of the quality of care, treatment, and services.

(u) Oversee the maintenance of quality control programs, as appropriate.

b. **Section Chairs**

(1) Qualifications - Each chair shall be and remain a member in good standing of the active staff and a member of the section service, shall be qualified by training, experience, and interest and demonstrate current ability in the clinical area covered by the service, and shall be willing and able to discharge the administrative responsibilities of the office.

(a) Selection - The Medical Staff President, with input from the department chair, shall appoint a member of each section within a department who meets the above qualifications as chair of the section.

(b) Term of Office - Each chair of the section shall serve a term, commencing on appointment and continuing until a successor is appointed. Section chairs may succeed themselves. Removal as chair may be made by the chair of the department after conferring with the Medical Staff President.

(2) Each section chair shall:

(a) Account to the department chair for the effective operation of the section and for the discharge of all delegated tasks.

(b) Develop and implement, in cooperation with the department chair, programs to carry out the quality and appropriateness of care, the utilization and management functions assigned to the section.

(c) Exercise general supervision over all clinical work performed within the section.

(d) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair.

c. **Additional Officers** - The Board may, after considering the advice and recommendations of the MSEC, appoint additional practitioners to medical administrative positions within the medical center to perform such duties as are prescribed by the Board, or as defined by the amendments to these Bylaws. To the extent that any such officer performs any clinical function, the officer must become and remain a member of the Medical Staff in good standing. In all events, he/she must be subject to these Bylaws and to all other policies of the medical center, except to the extent so provided by the Board.

ARTICLE XI
STAFF DEPARTMENTS AND SECTIONS

11.1 Organization of Staff Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a chair that is appointed and has the authority, duties, and responsibilities as specified in Article X Section 10.1. Within each department, staff members shall be assigned to sections, based on their areas of professional practice.

11.2 Departments and Sections

a. **Current Departments** - The current departments are:

(1) Medicine
(2) Surgery
(3) Family Practice
(4) Emergency Medicine
(5) Radiology
(6) Pediatrics
(7) Neurosciences
(8) Cardiovascular Services

b. **Current Sections -** There shall be such sections as may be approved from time to time by the Board.

c. **Assignment to Departments and Sections** - Each member of the staff shall be assigned membership and clinical privileges in at least one department or section within a department. The exercise of privileges within each department and section shall be subject to the rules and regulations therein, and to the authority of the department chair and section chief. A staff member with privileges in more than one department or section shall vote and attend meetings in the department and section in which he/she holds primary privileges.

d. **Functions of Departments** - The primary responsibility delegated to each department by the Board are to ensure continuous quality improvement of patient care by evaluating the clinical skills and outcomes of individual practitioners and directing process improvements involving the delivery of care. To carry out this responsibility, each department shall:

(1) Participate in continuous quality improvement (CQI) activities at the request of the Medical Center's Quality Council (A committee reporting to the Administrative Executive Committee and the Medical Staff Executive Committee).

(a) Assist in establishing quality indicators to monitor processes and outcomes of services within the medical center departments.

(b) Assist in evaluating performance data and formulating action plans.

(2) Assist in the establishment of guidelines for the granting of clinical privileges within the department.
(3) Submit findings or recommendations to the Medical Staff Peer Review Committee, or initiate further investigation as appropriate, when findings relate to individual practitioners' performance.
(4) Conduct or participate in continuing education programs and graduate medical education.
(5) Assign one or more of its members to represent the department in interdisciplinary forums for the purpose of conducting research and developing guidelines and protocols for improving clinical outcomes.
(6) Appraise the performance of its members and suggest actions calculated to improve patient outcomes or to improve the processes by which care is delivered in the medical center.
(7) Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

e. **Functions of Sections** - Each service shall perform the functions assigned to it which may include, without limitation, conducting quality/utilization management activities, continuing education programs, and credentials review and privileges delineation.

ARTICLE XII
COMMITTEES

12.1 Designation, Structure, and Function

a. There shall be such standing and special committees of the Medical Staff ("staff") as may from time to time be necessary and desirable to perform the functions of the staff required by these Bylaws or necessarily incidental thereto.

b. All committees except the MSEC and the Nominating Committee shall be appointed by the Medical Staff President.

c. All staff members to serve on committees and committee chairs shall be appointed by the Medical Staff President except as otherwise provided in these Bylaws. All medical center personnel, other than staff members to serve on committees shall be appointed by the President/CEO. Committee appointments are for the Medical Staff year.

d. The department chairs may assign physicians from their departments to serve on medical center wide committees and interdisciplinary teams.

e. The tenure of committee members shall continue until a successor is appointed. A Medical Staff committee member, other than the ones serving ex-officio, may be removed by a majority vote of the Medical Staff committee. Non-Medical Staff members may be removed at will by the President/CEO.

f. All committees shall:

(1) Maintain a record of attendance at their meetings.
(2) Maintain a record of their proceedings.
(3) Submit timely reports of their activities and copies of the minutes of their meetings to the MSEC.

g. Vacancies on any committee shall be filled in the same manner in which original appointment to such committee was made.

h. Non-Medical Staff members attending Medical Staff committees shall not be members of the committees and shall not have voting rights.

12.2 Standing Committees - The standing committees are:

a. **Medical Administrative:**
(1) Medical Staff Executive Committee – MSEC
(2) Credentials Committee
(3) Nominating Committee
(4) Bylaws/Accreditation Committee

b. **Medical Professional:**
(1) Medical Staff Peer Review Committee
(2) Medical Records/Utilization Review Committee
(3) Cancer Committee
(4) Intensive Care Committee
(5) Radiation Safety Committee
(6) Quality Council

12.3 Medical Administrative Committees:

a. **Medical Staff Executive Committee -**

(1) The MSEC shall consist of three (3) members elected by the Medical Staff and twelve (12) members appointed by the Medical Staff President. The three elected positions are the President, Vice President, and Secretary. The twelve (12) appointed members are the chairs of the Departments/Sections of Anesthesia, Cardiovascular Services, Emergency Medicine, Family Practice, Medicine, Neurosciences, Pathology, Pediatrics, Radiology and Surgery; the Trauma Services Medical Director, and a representative of the Hospitalist Service. In addition to the Medical Staff members, either the President/CEO or his designee shall attend meetings of this committee as ex-officio members, but he/she shall not be a member and will not vote. The Vice President of Medical Affairs, Vice President of Patient Care Services, and Vice President of Professional Services may attend meetings of this committee as ex-officio members, but they shall not be members and will not vote.

(2) The MSEC shall meet monthly and more often, if necessary, when requested by the Medical Staff President or President/CEO. The MSEC is empowered to act, within the scope of its responsibilities, for the Medical Staff between meetings of the full Medical Staff.

(3) Permanent records shall be made of all proceedings, and shall document the reporting of conclusions, recommendations of, and actions taken by the committee.

(4) A quorum for the transaction of business shall be four (4) Medical Staff members.

(5) Duties of the MSEC shall be to:
- (a) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.
- (b) Coordinate the activities of and policies adopted by the staff departments and committees.
- (c) Receive and act on department and committee reports, and assign activity groups.
- (d) Implement policies of the Medical Staff not otherwise the responsibility of the departments.
- (e) Serve as a liaison between the Medical Staff, executive staff, and the Board.
- (f) Assure the access of consultative services in all disciplines to patients.
- (g) Provide input into the implementation of health care programs designed to meet identified community health care needs.
- (h) Recommend action to the President/CEO on matters of medical/administrative nature.
- (i) Fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the medical center.
- (j) Inform the Medical Staff of the accreditation programs and of the accreditation status of the medical center.
- (k) Provide for the preparation of all meeting programs of the Medical Staff, either directly or through delegation to a program committee or other suitable agent.
- (l) Review the credentials of all applicants and make recommendations to the Board for staff membership, assignments to departments, and delineating of clinical privileges.
- (m) Review bi-annually or more frequently as appropriate the pertinent information regarding the performance and clinical competence of staff members and specified professional personnel. The results of such reviews shall be used to make

appropriate recommendations for reappointments, renewals, and/or changes in clinical privileges.

(n) Insure professional and ethical conduct and competent clinical performance on the parts of all members of the Medical Staff and specified professional personnel.
(o) To initiate and/or participate in Medical Staff corrective action when warranted.
(p) Report at each department meeting or pertinent committee and department actions and administrative matters.
(q) Make recommendations to the Board pertaining to:
- the structure of the Medical Staff
- the mechanism used to review credentials and to delineate individual clinical privileges
- specific clinical privileges for each eligible individual
- quality improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities
- the mechanism by which membership on the medical staff may be terminated
- the mechanism for fair-hearing procedures
- review of and actions on reports of medical staff committees, departments, and other assigned activity groups

(r) Assist in establishing quality indicators to monitor processes and outcomes of services within the medical center departments.
(s) Assist in evaluating performance data and formulating action plans.
(t) To request, when deemed appropriate, evaluations of members of the medical staff in instances where reasonable grounds exist to question the practitioner's ability to exercise privileges requested or privileges previously granted.

(6) An MSEC member shall be removed from office if a two-thirds (67%) majority of the active staff vote is in favor of removal, and provided that the MSEC and the Board concur. Grounds for removal shall include, but not be limited to, mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office. Action directed toward removing a specific MSEC member from office may be initiated by submission to the MSEC of a petition seeking removal, signed by not less than twenty-five percent (25%) of the members of the active staff with voting rights, or by a signed petition of the remaining members of the MSEC.

b. **Bylaws/Accreditation Committee**

(1) The Bylaws Accreditation Committee shall consist of six members of the Medical Staff. Other Medical Staff members may be called to participate with the committee in a consultative role. There shall also be representation from the executive staff.

(2) The Bylaws Accreditation Committee shall meet annually or when necessary as requested by the chair.

(3) The duties of the Bylaws Accreditation Committee shall be to:

(a) Review and recommend revision of the Bylaws, Rules and Regulations of the Medical Staff as necessary to prevent their becoming obsolete or disregarded.

(b) Act on any suggested Bylaws, Rules and Regulations change proposed or requested by the Medical Staff.

(c) Receive and act upon matters of accreditation as recommended by the Joint Commission on Accreditation of Healthcare Organizations or other agencies or regulatory bodies that affect the medical center's operation.

(d) Work closely with the medical center's executive staff implementing medical center accreditation requirements.

c. **Credentials Committee**

(1) The Credentials Committee shall consist of a minimum of five (5) members including the Medical Staff Vice president who shall act as chair. There shall be at least four (4) members of the staff appointed by the Medical Staff President.

(2) The committee shall meet monthly or at the call of the chair.

(3) The duties of this committee shall be to:

(a) Review Medical Staff applications for appointments, reappointments, and changes in privileges and Medical Staff membership status as delineated in Article III.

(b) Report recommendations of Medical Staff appointments, membership status, department and section, clinical privileges, and special conditions associated with the committee's recommendations.

(c) Establish objective criteria for granting privileges in areas of multidisciplinary interest.

(d) Provide specific reasons when privileges are denied.

(e) Provide recommendations for remedial action when privileges are denied.

(f) Review specified professional personnel applications for granting and renewal of privileges as delineated in Article III.

(g) Report recommendations on granting or renewal of specified professional personnel privileges and special conditions associated with the committee's recommendations.

(h) Perform any other duties deemed appropriate by the Medical Staff President.

e. **Nominating Committee**

(1) The Nominating Committee shall consist of the three (3) immediate past Medical Staff Presidents with the most recent past President serving as chair.

12.4 Medical Professional Committees

a. Medical Staff Peer Review

(1) The Medical Staff Peer Review Committee shall consist of five (5) members of the Medical Staff with representation from at least the Departments of Surgery, Medicine, and Family Practice. Other members of the Medical Staff may be called to participate with the

Committee in a consultative role. There may also be attendance by and support from the Performance Improvement Staff, Risk Manager and the executive staff.

(2) The Committee shall meet within thirty (30) days of being referred a case or incident for review. The pertinent materials will be available in the Office of Medical Affairs for review prior to the meeting. The Committee Chairperson (or their designee) shall establish the date, time and location of the meeting with assistance from the Office of Medical Affairs. The practitioner(s) whose performance and/or conduct is being reviewed should be involved in the discussion at the initial or subsequent meetings before a formal report is made.

(3) Cases to be reviewed by the Committee may include:
- (a) Surgical and/or procedure complications.
- (b) Improper use of medications/blood products.
- (c) Reports of inappropriate behavior or conduct by members of the Medical Staff or specified professional personnel.
- (d) Sentinel Events.
- (e) Significant deviations from norms monitored by quality improvement indicators as identified by Department chairs.
- (f) Cases referred by the Medical Executive Committee or other Medical Staff Departments or Committees.
- (g) Unusual occurrence reports requiring additional input.

(4) Following their evaluation, the Committee shall file a formal report of their findings with the Office of Medical Affairs within fifteen (15) days. Findings will then be forwarded to the Credentials Committee and Medical Staff Executive Committee as necessary. Rationale for the recommendations, including references to medical literature, clinical guidelines, and practice standards, should be made part of the report. Minority opinions, if any, should also be included. A letter reviewing the findings shall be sent to the involved parties for their comments. The Committee may choose to reconvene to discuss the responses.

(5) If the Committee chooses, the case may be referred to an outside reviewer agreed upon by the Committee with the assistance of the Office of Medical Affairs. Circumstances requiring outside review include the need for additional expertise on a case or a significant conflict of interest between the Committee and the parties involved in the case.

(6) The Medical Staff Executive Committee shall accept, modify, or reject the recommendations of the Committee within thirty (30) days or at its next scheduled meeting following receipt of the report. Any issues referred by the Committee and agreed upon by the involved Medical Staff Executive Committee will be placed in the practitioner's file and will be available for review at the time of reappointment.

(7) Implementation of any recommendations by the Committee and follow-up of those recommendations will be coordinated by the Office of Medical Affairs and monitored by the Quality Management Department as appropriate.

(8) All findings of the peer review process will be privileged, confidential, and protected under the Medical Studies Act.

b. **Medical Records/Utilization Review Committee**

(1) The Medical Records/Utilization Review Committee shall consist of the Medical Staff Secretary who shall serve as chair and six (6) members of the Medical Staff appointed by

the Medical Staff President. The President/CEO may appoint such hospital representatives to attend and support this committee as he/she may determine in his/her discretion.

(2) The Medical Records/Utilization Review Committee shall meet at least quarterly and as necessary when requested by the chair.

(3) The duties of this committee shall be to:

(a) Review, at least quarterly, the quality of medical records for clinical pertinence and timely completion.

(b) Determine or recommend the format of the medical record, the forms used in the medical record, and the use of electronic data processing and storage systems for medical record purposes.

(c) Assure, in accordance with the medical center's utilization review program, appropriate allocation of the hospital's resources.

(d) Review the medical center's utilization review program.

(e) Address utilization problems as identified through quality, assurance activities and other relevant documentation.

(f) Perform concurrent review, in conjunction with the medical center's utilization review program, which focuses on those diagnoses, problems, procedures, and/or practitioners with identified or suspected utilization related problems.

(g) Facilitate discharge as soon as acute level of care is no longer required, in conjunction with the discharge planning portion of the medical center's utilization review program.

(h) Assist in the annual review and evaluation of the hospital's utilization review program.

(i) Evaluate the medical necessity for continued medical center services for particular patients in accordance with professional review organization (PRO) standards, rules and regulations.

(j) Perform any other duties deemed appropriate by the Medical Staff President.

c. **Cancer Committee**

(1) The Cancer Committee is a multidisciplinary committee to consist of Medical Staff representatives from the Departments/Sections General Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology and the Cancer Liaison physician. There shall also be support from Patient Care Services, Social Services, Cancer Registry, Executive Staff, Cancer Program Administrator, and Performance Improvement.

Other medical center personnel may be called to participate with the committee in a consultative role.

(2) The Cancer Committee shall meet at least quarterly or when necessary as requested by the chair.

(3) The duties of the committee shall be to:

(a) Be responsible for and accountable for all cancer program activities at the medical center.

(b) Follow the current standards set forth by the American College of Surgeons Commission on Cancer for approved cancer programs.

(c) Select a coordinator for each of the following areas of Cancer Committee activity: cancer conferences, quality control of cancer registry data, performance improvement, and community outreach.

(d) Develop annual goals and objectives for clinical, community outreach, and performance improvement.

(e) Evaluate annual goals and objectives for clinical, community outreach, and performance improvement activities.

(f) Establish Cancer Conference frequency, format, and multidisciplinary and attendance requirements for Cancer Conference on an annual basis.

(g) Evaluate the required number of cases discussed at Cancer Conferences and make sure that 75 percent of the cases discussed are presented as prospective cases.

(h) Monitor and evaluate Cancer Conference frequency, multidisciplinary attendance, cases presented, and prospective cases on an annual basis.

(i) Evaluate the plan for quality of cancer registry data and activity on an annual basis.

(j) Complete and review the site-specific analysis that includes comparison and outcome data and disseminate the results of the analysis to the Medical Staff.

(k) Review at least 10 percent of the analytic caseload to ensure the AJCC staging is assigned by the managing physician and recorded on the staging form in the medical record.

(l) Review or have one specific physician review 10 percent of the analytic caseload to ensure that 90 percent of the cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols.

(m) Provide a mechanism to educate patients about cancer-related advanced research.

(n) Review reports for cancer-related advanced research with number of cases and policy for patient awareness at least on an annual basis.

(o) Offer one cancer-related educational meeting in addition to Cancer Conference for physicians annually.

(p) Monitor community outreach activities on an annual basis.

(q) Complete and document required studies to measure quality control and outcome.

(r) Implement at least two improvements that will directly affect patient care.

(s) Establish subcommittees as needed to fulfill requirements or be able to meet the guidelines set forth by the Commission on Cancer for the cancer program at Saint Francis Medical Center.

d. **Intensive Care Committee**

(1) The Intensive Care Committee consists of medical staff representation from Anesthesiology, General Surgery, Medicine, and three (3) physician members at large. There shall also be attendance by and support from patient care services, critical care services, and executive staff.

(2) The Intensive Care Committee shall meet at least quarterly or when necessary as requested by the chair.

(3) The duties of the committee shall be to:

(a) Assist and advise on the operation of the coronary intensive care, surgical intensive care, cardiac progressive care, neuroprogressive care, and other special care units as designated.

(b) Establish and monitor policies/procedures for the intensive care units.

(c) Monitor the care provided for patients in the intensive care units.

(d) Provide continuing education to members of the Medical Staff and medical center staff regarding the care of the intensively ill patients.

e. **Radiation Safety Committee**

(1) The Radiation Safety Committee shall consist of Medical Staff representation from the Department of Radiology to include three (3) members at large, one authorized user for each type of use permitted by the license granted the hospital by the United States Nuclear Regulatory Commission. Other voting committee members shall include the V.P., Professional Services; Director, Radiation Oncology Center; Director, Radiology; and the Lead Nuclear Medicine technician. Others may attend at the request of the committee as ex officio members.

(2) The Radiation Safety Committee shall meet quarterly or when necessary as requested by the chair.

(3) The duties of the Radiation Safety Committee shall be to:

(a) Review all proposals for therapeutic use of radio nuclei.

(b) Make recommendations concerning practitioners having suitable training and experience to perform nuclear medicine procedures.

(c) Develop policies/procedures regarding the storage, transportation, and disposal of radioactive materials.

(d) Recommend action when there is failure to observe protection recommendations, rules, and regulations.

(e) Establish rules for patient care and other individuals who are in contact with patients receiving therapeutic amounts of radio nuclei rules relating to the discharge of such patients and rules to protect personnel involved when such patients under surgical procedures for autopsy.

f. **Quality Council**

(1) The Quality Council shall consist of 6 members of the Medical Staff. Other members of the Medical Staff may be called to participate with the Council in a consultative role. The Council shall be co-chaired by one member of Council and the Vice President, Medical Affairs. There shall also be attendance and support by other members of the Executive Staff. The Quality Coach/patient safety officer shall also participate.

(2) The Quality Council shall meet bi-monthly or when necessary as requested by the Chair.

(3) The duties of the Quality Council shall be to:

(a) Provide oversight and direction for all organizational quality measurement, assessment and improvement activities.

(b) Assist in the development, revision and implementation of the "Plan for Improving Organizational Performance" and evaluate its effectiveness.

(c) Evaluate recommendations for performance improvement and quality assessment projects related to patient care and safety. Establish priorities and allocate resources appropriately.

(d) Monitor the progress of performance improvement and quality assessment projects.

(e) Conduct general audits or reviews as requested by the Medical Staff Executive Committee and Administrative Executive Committee.

(f) Make recommendations to the Administrative and Medical Staff Executive Committees on matters of quality.

ARTICLE XIII
MEETINGS

13.1 General Staff Meetings

a. **Routine Meetings** - The Medical Staff shall hold routine staff meetings as needed, except that there shall be at least an annual meeting, at which the election of officers shall be conducted.

b. **Special Meetings** - Special meetings of the staff may be called at any time by the Board, the Medical Staff President, the MSEC, or shall be called by the Medical Staff President within ten (10) days after receipt of a written request of at least twenty-five percent (25%) of the members of the active staff, and shall be held at the time and place designated for the meeting except that stated in the meeting notice.

c. **Order of Business and Agenda** - The order of business at each meeting shall be determined by the Medical Staff President. The agenda shall include at least:

(1) Acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
(2) Administrative reports from the President/CEO, Medical Staff President, and departments and committees as necessary.
(3) The election of officers and of representatives to staff committees, when required by these Bylaws.
(4) New Business.

13.2 Committee and Department Meetings

a. **Routine Meetings** - Committees, departments, and sections may, by resolution, provide for the time for holding routine meetings and no notice other than such resolution shall be required.

b. **Special Meetings** - A special meeting of any committee, department, or section may be called by, or at the request of, the chair thereof, the Board, the Medical Staff President, or shall be called by the chair within ten (10) days after receipt of a written request of at least twenty-five percent (25%) of the group's then current voting members. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.3 Notice of Meetings

Written or printed notice stating the place, day, and hour of any general staff meeting, of any special meeting, or of any routine committee, department, or service meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than five (5) days nor more than fifteen (15) days before the date of such meeting. Notice of department, service, and committee meeting may be given orally. If mailed, the notice of the meeting shall be deemed delivered forty-eight (48) hours after deposited, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his/her address as it appears on the records of the medical center. Personal attendance at a meeting shall constitute waiver of notice of such meeting.

13.4 Quorum

a. **General Staff Meetings** - The presence of fifty percent (50%) of the voting members of the active staff at any regular or special meeting shall constitute a quorum for the purposes of amendment to these Bylaws and of the staff rules and regulations. For all other business, members present, but not less than three (3) shall constitute a quorum.

b. **Department, Section, and Committee Meetings** - Voting members present, but not less than three (3) members shall constitute a quorum at any meeting of such department, section or committee. Members specifically described as ex-officio shall not be counted in determining the presence of a quorum.

13.5 Manner of Action

Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting in a meeting at which a quorum is present, shall be considered the action of the group. Action may be taken without a meeting by a department, section, or committee of the Medical Staff by a written document setting forth the action so taken signed by each member entitled to vote thereat. Non-physician participants of Medical Staff committees appointed by the Medical Staff President in conformity with Article XII Section 12.1(c) shall not have the right to vote. This provision shall not apply to medical center wide committees and interdisciplinary teams.

13.6 Minutes

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer and forwarded to the MSEC, and made available to the staff as appropriate. A permanent file of the minutes of each meeting shall be maintained.

13.7 Attendance Requirements

a. **Regular Attendance** - Each member of the active staff is recommended to attend during his/her two-year term of appointment at least fifty percent (50%) of all meetings of the general staff, department, section, and committee of which he/she is a member.

If they cannot attend, they are responsible for seeking out the information. A variety of mechanisms exist to obtain the information, e.g., the department chair, MSEC members, and leaders of the medical center.

b. **Special Appearance** - A staff member whose activities are scheduled for discussion at a regular department, section, or committee meeting shall be given notice of the matter and of the time and place of the meeting at least five (5) days prior to the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, special notice shall be given and shall include a statement of the issue involved and that the staff member's appearance is mandatory. Failure of a staff member to appear at any meeting with respect to which he was given such notice may, unless properly excused upon a showing of good cause, result in an automatic suspension of all or such portion of the staff member's clinical privileges as the MSEC may direct.

ARTICLE XIV
GENERAL PROVISION

14.1 Department Rules and Regulations

Subject to the approval of the MSEC and the Board, each department, as needed, shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general rules and regulations of the staff, or other policies of the hospital. A permanent file of current department rules and regulations shall be maintained by the President/CEO.

14.2 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Board after considering the advice of the MSEC.

14.3 Headings

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

14.4 Transmittal of Reports

Reports and other information which these Bylaws require the staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the President/CEO.

14.5 Designees to Perform Functions of the President/CEO

Any responsibility assigned or authority granted to the President/CEO may be fulfilled or exercised by another executive staff member of the medical center, designated by the President/CEO or the Board to perform such functions, except as otherwise provided by the Board or in the medical center's corporate bylaws.

14.6 Good Standing

The prerogatives and rights provided by these Bylaws to staff members to vote at staff meetings, to be nominated for and to hold staff office or serve as a member of the MSEC, and to serve as a department or section officer or committee chair, shall be limited to staff members in good standing.

14.7 Professional Liability Insurance

Each practitioner granted clinical privileges in the medical center shall maintain professional liability insurance in force and provide supportive documentation of such as may be requested, in amounts not less than the minimum amounts as from time to time may be determined by the MSEC and/or of the Board; or provide other proof of financial responsibility in such manner as the Board may from time to time establish. The minimum amount of required coverage established pursuant to this provision shall not exceed the amount of professional liability insurance carried by the medical center. Such practitioner shall also be required to notify administration of any reduction in coverage or other significant change which effectively reduces or limits coverage within five (5) days of being so notified.

14.8 Professional Liability Actions

Any medical/legal action against a member of the Medical Staff that results in a court awarded judgment or a settlement out of court shall be reported to the President/CEO at the time the judgment or settlement is effected.

14.9 Not a Contract

These Bylaws and the Rules and Regulations are not a contract between the staff and any applicant, member or practitioner or between the Board or medical center and any applicant, member or practitioner.

14.10 Conflict Resolution

A conflict exists when two or more values, perspectives, beliefs or interests are contradictory in nature and have no current alignment or agreement. In the event a conflict arises between key leadership groups (the Board of Directors, Executive Team or Medical Staff Executive Committee) that could adversely affect patient safety or quality of care, any one of the groups may invoke the Medical Center's Conflict Management for Leadership Group's policy to facilitate resolution.

ARTICLE XV
ADOPTION AND AMENDMENT OF BYLAWS, RULES, AND REGULATIONS

15.1 Staff Responsibility and Authority

The staff shall have the initial responsibility and delegated authority to formulate and to submit recommendations to the Board regarding Medical Staff Bylaws, Rules and Regulations, and amendments thereto. If the voting members of the Medical Staff propose to adopt a rule, regulation, or medical staff policy, or an amendment thereto, they first must communicate the proposal to the MSEC. If the MSEC proposes to adopt a rule or regulation, or an amendment thereto, it first must communicate the proposal to the Medical Staff; when it adopts a medical staff policy or an amendment thereto, it must communicate this to the Medical Staff. Should there be a disagreement or conflict between the Medical Staff and the Medical Staff Executive Committee, a special meeting of the Medical Staff may be called pursuant to Section 13.1(b) of these Bylaws to address the dispute/conflict. All amendments or revisions shall be effective when approved by the Board, and it shall be the duty and responsibility of the Board to uphold the Medical Staff Bylaws, Rules and Regulations, and Policies that have been approved. The Board shall be the final arbiter of any dispute or disagreement concerning proposals to adopt a rule, regulation, medical staff policy or an amendment thereto, as well as the interpretation, meaning, or applicability of any provision of these Bylaws, Rules and Regulations, or amendments thereto. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner.

15.2 Methodology

a. Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

(1) **Staff** - The affirmative vote of a majority of the Medical Staff members eligible to vote on this matter who are present at a general or special meeting of the Medical Staff at which a quorum is present, provided at least seven (7) days written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action. To address potential changes in a timely manner, mail-out ballot/vote, with proposed amendments attached, may be utilized in lieu of a general staff meeting to obtain a majority vote of those authorized to vote as deemed appropriate by the Medical Staff President.

(2) **Board** - The affirmative vote of a majority of the Board, provided, however, that in the event that the staff shall fail to exercise its responsibility and authority as required by Section 15.1 above, and after notice from the Board to such effect including a reasonable period of time for response, and implementation of the Medical Center's policy on Conflict Management for Leadership Groups, the Board, in order to carry out its obligation of holding the Medical Staff accountable and to carry out its responsibility for the quality and safety of care, may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, staff recommendations and views shall be carefully considered by the Board during its deliberations and in its actions which shall be pursuant to this section.

b. The Medical Staff Rules and Regulations may be adopted, amended, or repealed by:

(1) **Staff** - The affirmative vote of a majority of the medical staff members eligible to vote on this matter who are present at a general or special meeting of the Medical Staff at which a quorum is present, provided at least seven (7) days written notice, accompanied by the proposed Rules and Regulations and/or alterations, has been given of the intention to take such action. To address potential changes in a timely manner, mail-out ballot/vote, with proposed amendments attached, may be utilized in lieu of a general staff meeting to obtain a majority vote of those authorized to vote as deemed appropriate by the Medical Staff President.

(2) **MSEC -** Subject to approval by the Board, the staff may empower the MSEC to adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MSEC is empowered by the staff to provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MSEC. The Medical Staff will have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MSEC, the provisional amendment stands. If there is a conflict over the provisional amendment, the Board shall be the final arbiter of the dispute. If determined necessary, a revised amendment may be submitted to the Board for action.

(3) **Board** - The affirmative vote of a majority of the Board in the event that the staff shall fail to exercise its responsibility and authority as required by Section 15.2 a (2) above.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 10th Day of Sept., 2002.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 19th DAY OF September, 2002.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 2nd Day of Dec., 2003.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 3rd DAY OF December, 2003.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 6th Day of June, 2006.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 14TH DAY OF SEPTEMBER, 2006.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 11th Day of SEPT., 2007.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 13TH DAY OF SEPTEMBER, 2007.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 8th Day of JAN., 2008.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 10TH DAY OF JANUARY 2008.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 7TH Day of APRIL, 2009.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 16TH DAY OF APRIL, 2006.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 14th Day of SEPT., 2010.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 28TH DAY OF SEPTEMBER, 2010.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 4th Day of JAN., 2011.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 13th – Day of JANUARY, 2011.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 6th Day of DEC., 2011.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 8th – Day of DECEMBER, 2011.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 7th Day of JAN., 2014.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 16th – Day of JANUARY, 2014.

SAINT FRANCIS MEDICAL CENTER
RULES AND REGULATIONS OF THE MEDICAL STAFF

ARTICLE I

ADMISSION, OBSERVATION, TRANSFER OF CARE AND DISCHARGE

1.1 Admission and Observation

a. Physicians, oral surgeons and podiatrist members of the Associate, Active, Consulting and Courtesy categories of the Medical Staff may admit inpatients and care for outpatients.

b. If in the practitioner's judgment a patient does not meet criteria for inpatient admission, the practitioner may elect to observe the patient on an outpatient basis. The clinical criteria for outpatient observation and reimbursement vary among government agencies and commercial carriers. Utilization Review personnel are available to discuss alternatives on a case by case basis.

c. All patients, regardless of status as inpatient, outpatient, or emergency department patient, must provide general consent for treatment. Implied consent is recognized in emergency situations for patients who are otherwise unable to provide consent because of their status as minors or incapacity.

d. Inpatients must have a designated attending practitioner who is responsible for providing continuous care from the point of admission to the point of discharge. Unless otherwise documented at the time of admission, the admitting practitioner shall be the attending practitioner.

1.2 Designation of Attending Physician for Emergency Department Patients

The Emergency Services physician on duty shall determine the appropriate specialty for the purpose of arranging for the admission of patients who are initially seen in Emergency Services. In the event the patient has no local doctor for the purpose of admission, the Emergency Services physician on duty shall contact the physician on-call for the particular specialty required in the judgment of the Emergency Services physician. The physician on-call for that specialty shall then be deemed the admitting and attending physician until such time as care is properly transferred to another practitioner.

1.3 Role of the Attending Practitioner- Transfer of Care

The admitting practitioner is deemed the attending practitioner until such time as the patient's care is transferred to another practitioner. To properly effect a transfer of care, the referring practitioner should obtain the intended receiving practitioner's consent prior to ordering the transfer of care. If the intended receiving practitioner objects to the transfer of care, the current attending practitioner shall remain responsible for the continuous care of the patient until another practitioner consents to serve as the attending practitioner. This provision does not affect the involvement of consulting practitioners.

The President of the Medical Staff or his/her designee is authorized to intervene in decisions regarding the transfer of inpatients from one patient care center to another, e.g., the transfer from ICU to a medicine center or surgical center.

1.4 Regular Attendance of Inpatients (Acute Level of Care Only)

The attending practitioner (practitioner of record) shall visit his/her patients daily. This requirement is not applicable to patients needing a non-acute level of care which have different frequency of visitation requirements.

ARTICLE II
CONSULTATION

2.1 Any qualified practitioner with clinical privileges in the institution can be called for consultation within his/her area of expertise.

2.2 If a member of the medical staff is unable to obtain a requested consultation within a reasonable amount of time in consideration of the patient's condition and the institution's objective to provide for the efficient delivery of care, the President of the Medical Staff is authorized to designate another member of the medical staff to provide the needed consultation.

2.3 Members of the medical staff are responsible for arranging for consultations. Hospital staff may assist in communications in carrying out orders related to the arrangement for consultation, but the requesting practitioner is ultimately responsible for obtaining the consultant's consent.

2.4.1 Consultative reports shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. When operative procedures are involved, the surgical consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

2.4.2 If a clinical situation arises in which the patient’s needs exceed the attending practitioner's privileges, the Medical Director, Department or Section Chair, or Medical Staff President, may request that consultation be pursued. Consultation should also be pursued upon request of the patient or patient’s designated representative.

ARTICLE III
MEDICAL RECORD DOCUMENTATION

3.1 The admitting or attending practitioner is responsible for documenting the initial history and physical report and the discharge summary. If granted privileges to do so, specified professional personnel may perform a patient's history and physical. The sponsoring physician, must, consistent with Medical Center policy, confirm and endorse in writing the findings, conclusions and assessment of risk prior to diagnostic or therapeutic interventions.

3.2 All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated (authentication means by written or electronic signature).

3.3 Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations should be kept on file in the Health Information Management Department and on the patient care zones. Do not use:

- U or u
- Q.O.D. or q.o.d.
- MSO4
- IU
- Trailing zero, as in 5.0
- Q.D. or q.d.
- MS
- MgSO4
- Lack of Leading zero, as in 0.5

3.4 Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of patient discharge.

3.5 All patients' records are the property of the Medical Center and shall not be removed from the building without a court order or subpoena, the original of all reports shall be filed in the medical record. Copies of the original record may be made and issued for justifiable reasons with the consent of the patient, the attending physician and the President of the Medical Center. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

3.6 Access to all medical records of all patients shall be afforded to members of the medical staff for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MSEC before records can be studied.

3.7 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.

3.8 The patient's medical record is to be completed within the time period delineated in Article V, Delinquent Chart Rules.

3.9 Discharge Summaries - Discharge summaries shall include the following items of information in language customarily used by members of the same medical specialty practicing in the same or similar locality:

a. Reason for admission
b. Significant findings from exams, tests, procedures
c. Procedures performed
d. Treatment rendered
e. Patient's condition upon discharge or transfer
f. Disposition
g. Final diagnosis
h. Discharge status and instructions provided to the patient or care-givers.

3.10 Release of Information - Information from medical records shall be released only on written authorization signed and dated by the patient, legal guardian, nearest relative or executor in case of death. All authorizations shall be dated within the past three (3) months.

3.11 Medical record contents - All patient records shall contain:

a. Identification data
b. The patient's medical history
c. A summary of the patient's psychosocial needs
d. A relevant physical examination
e. Diagnostic and therapeutic orders
f. Evidence of the informed consent
g. Clinical observations
h. Results of therapy
i. Reports of diagnostic procedures
j. Results of therapeutic procedures

3.12 Inpatient medical records shall contain documentation of the following items of information when applicable:

a. Identification data
b. The medical history of the patient
c. Report of physical examination
d. A statement of the conclusions of impressions from the admitting history and the physical examination
e. A statement of the treatment(s) planned
f. Diagnostic and therapeutic orders
g. Evidence of informed consent
h. Clinical observations
i. Physician's progress notes
j. Consultation reports
k. Pertinent information from nursing notes & entries by nursing and allied health providers
l. Results of tests and treatments
m. Clinical laboratory reports
n. Pathological laboratory reports
o. Radiology and nuclear medicine examination reports
p. Anesthesia record
q. Organ harvesting or transplantation records
r. Identification of implanted devices
s. Discharge summary
t. Autopsy report

3.13 Except as may be provided for by policies and procedures adopted by the Medical Staff or the Medical Record/Utilization Review Committee, Outpatient Medical Records shall contain:

a. Identification data
b. The patient's medical history
c. A summary of the patient's psycho social needs
d. A relevant physical examination
e. Diagnostic and therapeutic orders
f. Evidence of informed consent
g. Clinical observations
h. Results of therapy
i. Reports of procedures and tests and their results
j. Conclusions at the end of treatment
k. Problem List (Summary List)

3.14 History and Physical Examination

a. A complete admission History and Physical examination shall be dictated and placed in the medical record within twenty-four (24) hours of admission but prior to surgery or a procedure requiring anesthesia services.

b. The inpatient History and Physical report shall contain:
   (1) The chief complaint
   (2) Present illness
   (3) Assessment of the patient's emotional, behavioral, and social status
   (4) Relevant past, social and family histories appropriate to the age of the patient
   (5) An inventory of body systems
   (6) A complete physical examination
   (7) Current medications and dosages
   (8) Allergies

c. An inpatient History and Physical for children or adolescents shall contain all of the above and:
   (1) Evaluation of the patient's developmental age
   (2) Consideration of educational needs and daily activities
   (3) Immunization status
   (4) The family's expectations for and involvement in care of the patient
   (5) A summary of the patient's psychosocial needs appropriate to the age of the patient

d. Observation Patients - Observation Charts shall contain:
   (1) Chief complaint
   (2) Present illness
   (3) Relevant past, social and family histories appropriate to the age of the patient
   (4) Assessment of the patient's emotional, behavioral, mental and social status
   (5) Current medications and dosages
   (6) Allergies
   (7) Inventory of body systems
   (8) A complete physical examination
   (9) If the observation patient is age 0-14 years, the following must also be documented:
      (a) Evaluation of the patient's developmental age
      (b) Consideration of educational needs and daily activities
      (c) Immunization status
      (d) The family's expectations for and involvement in care of the patient.

e. Continuity of Care from Outpatient to Inpatient

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Documentation of patient care shall be completed at least daily during the patient's hospitalization.

f. A complete and accurate emergency record shall be maintained on all emergencies.

g. Office History and Physical – A History and Physical initiated and legibly recorded by a member of the medical staff within thirty (30) days of admission and updated with all of the information listed in Section 3.14(b) may be used in the patient's hospital record. In such instances, the H&P must be completed by updating the record with all additions and/or changes to the initial H&P within 24 hours of admission but prior to surgery or a procedure requiring anesthesia services.

i. Pre-procedure H&P - When the History and Physical exam is not placed in the medical record before any operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

j. Transfers from acute care center - Transfers from an acute care location within the Medical center to either the DRG-exempt Rehabilitation Unit of the Skilled Nursing Facility require a discharge summary from the acute care bed which can be utilized as the readmission history and physical.

k. Routine and Standing Orders – Routine orders shall be permissible only when ordered by the physician. To be acceptable, the orders must be placed onto the patient's record and authenticated by the practitioner. Date, time, and signature are required for authentication.

3.15 Informed Consent

a. The Medical Staff has defined the procedures for which informed consent is required. The specific procedures are outlined in the Medical Center's policy *Informed Consent/Decision Making.*

ARTICLE IV
ORDERS

4.1 Routine Orders - Must be transcribed onto an order sheet in the medical record and authenticated by the ordering practitioner, to include the date and time of the authentication.

4.2 All verbal or telephone orders must be authenticated by the responsible practitioner attending the patient or their covering physician within 48 hours of the order being given. Date**,** time and signature are required for authentication. Restraint orders must be signed/reordered daily.

4.3 Any licensed individual may accept a practitioner's verbal orders within the limitations of the licensure as may be prescribed by the Revised Statutes or Code of State Regulations of the State of Missouri.

4.4 Medication Orders

a. Pharmacy will review all medications on the patient's seventh (7th) day of admission and each successive seventh day.
b. The progress notes will be stamped by Pharmacy indicating the date on which medications were reviewed.
c. Any pharmacist's recommendations will be communicated to the attending physician.
d. Automatic Cancellation of Drug Orders and Drug Regimen Review - The Hospital's Policy and Procedure for the timing and frequency of automatic cancellation orders shall apply.
e. Generic substitution is acceptable at the medical center.
f. Therapeutic interchange is allowable at the medical center with specific approval by the MSEC and the Medical Staff.

4.5 Respiratory Therapy - Orders shall specify type, frequency, and duration of treatment and the type and dose of medication. A 72-hour re-order requirement will apply.

4.6 All orders for restraints must be authenticated on the restraint form on a daily basis according to the Medical Center Restraint Policy.

ARTICLE V
DELINQUENT CHART RULES

5.1 Delinquent Medical Records

a. A medical record shall be considered incomplete if it is lacking reports, written documentation, or signatures which prevent it from being permanently filed.

b. Incomplete records shall become delinquent fifteen (15) days after being placed in the practitioner's incomplete record box. On the 15th day the practitioner will be notified of his/her delinquent records.

c. Failure without cause to complete medical records within thirty (30) days of the patient's discharge will be deemed a voluntary relinquishment of clinical privileges. This is not an event reportable to the National Practitioner Data Bank. There shall be no deemed voluntary relinquishment when the delay is attributable to the practitioner's illness or excusable absence. The determination as to whether an absence resulting in a delay in the completion of medical records shall be excused shall be made by the Executive Committee of the Medical Staff.

ARTICLE VI
GENERAL RULES REGARDING SURGERY

6.1 Block Scheduling

a. The scheduling of elective surgery is done using block scheduling. Assignments of blocks will be at the discretion of the Director of Surgical Services, Chief of Anesthesia, and Chief of Surgery, in consultation with the Operating Room Steering Committee.

b. Utilization of s\assigned blocks will be evaluated quarterly and reallocated based on utilization guidelines and new block requests.

c. Retention of assigned blocks is based upon the following:

1. Utilization of each block must be maintained at fifty percent (50%). Utilization both within as well as outside of the designated block will be calculated, from induction of anesthesia of the first patient until transfer to PACU of the last patient. The 50% utilization will be based upon time within the designated block. Turnover is defined as the time from when the dressing is applied to the patient to the incision time of the surgeon's next patient.
2. Education time or vacation time is not included in the calculation as long as the Surgery ACC desk is notified ***one*** week in advance to release a block.
3. If a surgeon continually arrives late (***defined as 15 minutes past*** scheduled time) more than 50% of the time in the quarter for an assigned block, the surgeon will be placed on "review" and notified. If arrival time does not improve in the following quarter, the block will be reallocated or the start time moved back a ½ hour. If a surgeon had the start time of 0700 and is late 15 minutes more than 2 times a month, that surgeon will lose his 0700 start time for a quarter and be moved back ½ hour later**.**
4. Quarterly review will determine if the block is being maintained at 50% utilization. Surgeons with blocks which are utilized less than 50% will be sent a letter by the Chief of Surgery, Chief of Anesthesia or Director of Surgical Services. If block utilization is 50% or less for three (3) consecutive months, the block will be reallocated.

d. Block time will become open block by 0800, forty-eight (48) hours preceding the block. Block time will become open on Thursday at 1200 noon for all Monday blocks.

e. The surgeon must establish in-house availability before anesthesia personnel can proceed with intubation.

f. A ventilator patient will not be brought to the OR until the surgeon of the patient is present in the hospital.

6.2 No elective surgical case will be started when the OR is on the emergency generator, disaster or lock down.

6.3 Definition and Scope of Assessment for Emergent and Non-Emergent Patients

a. A non-emergent patient is one in which the patient is hemodynamically stable and the procedure may be done electively. For these patients the assessment documentation must include:

1. A complete history and physical done within thirty (30) days to the procedure.
2. Diagnostic testing will be at the discretion of the surgeon or anesthesiologist.
3. Informed consent with risk, benefits, and alternatives explained to the patient.
4. Documented plan of care.
5. Update the history and physical within twenty-four (24) hours of the surgical

procedure.

6. The site marking must be completed in the preoperative area or the surgeon's office as needed per the "Site Marking" policy.

b. An emergent patient is one whose condition may be hemodynamically unstable, requiring operative or invasive management. In these cases, it may not be possible to complete the usual assessment requirements, but the documentation should include:

1. Brief admission note with pre-operative differential diagnosis and plan of treatment.
2. Laboratory and other diagnosis tests as allowable due to the emergency.

6.4 In the event of emergency surgery which will delay another case, the surgeon with the emergency case must notify the surgeon being "bumped". "Bumping" is determined by assessing the schedule. This will be done by the float anesthesiologist and the assistant manager, OR manager or Director of Surgical Services. When at all possible, the surgeon "bumped" will be from the same practice or service line.

6.5 When two surgeons are performing simultaneous procedures on a patient, both surgeons must be in the facility and available before the patient will be anesthetized. When sequential procedures are being performed, surgeon arrival time must be coordinated through and confirmed by the assistant manager or center core nurse before the patient is anesthetized.

6.6 Pre-surgical laboratory tests will be performed at the discretion of the admitting surgeon or anesthesiologist.

6.7 A signed surgical permit is required on all patients prior to the surgical procedure, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient.

a. The surgeon is required to document what procedure is to be performed on the patient. This documentation may either be noted on the progress notes, at the end of the History and Physical, written as an order, or can be given as a verbal orders. Verbal orders need to be signed within 48 hours.

b. In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from patients, guardian or next of kin, two physicians must document on the patient's medical record that the condition is life or limb threatening.

6.8 The anesthesiologist must evaluate each patient preoperatively, record and sign an anesthesia note on the patient's record.

6.9 A post-anesthesia evaluation will be made by anesthesia and a post-operative note made.

6.10 When scheduling an emergency surgical procedure, the surgeon will contact surgery direct and the anesthesiologist personally so as to discuss any pertinent factors. The only exception will be when the surgeon is involved in the care of a patient with a life threatening condition.

6.11 If a surgeon or surgeons opt to schedule non-life or non-limb threatening cases on a weekend, that are longer in duration than one hour, these cases must be staggered to keep staff available for emergent cases. Scheduling will be done on a first-come, first-serve basis. Cases can be bumped if another case has higher priority. In this event, the surgeons and anesthesiologist will confer with each other to decide who will be scheduled first. If a surgeon decides to do a case which averages longer than 2 hours, in which the team will be tied up for emergent cases, the surgeon must talk with the anesthesiologist on call and the Trauma doctor on call to inform them that the specific specialty will not be available for emergent cases. The trauma surgeon will then determine if an emergent case presents in ER if the case will need to be transferred elsewhere. The Administrator on call will also have to be notified by the surgeon as well. Two surgical

teams will be allowed to work after hours and on weekends. The third team will be utilized only for true emergent cases and another case will not be started until the emergent case is finished. The determination of any exception will be made by the anesthesiologist on call, surgeon and administrator on call. If there is still an issue, the Department Chairperson and/or the President of Medical Staff will be called.

6.12 Tissue removed during a surgical procedure must be sent to the Pathology Department in accordance with the Policy entitled "Specimens to Pathology".

6.13 The necessity of surgical assistants is left up to the discretion of the operating surgeon. The hospital as a rule does not provide surgical assistants to non-employed surgeons. The hospital, at times if schedule permits, provides a retractor holder to be available if needed.

6.14 A physician with minor privileges who schedules a case which may develop into a major case must give the name of the surgeon who would perform the major procedure, if necessary, at the time the case is scheduled.

6.15 Operative Notes/Reports shall be written or dictated immediately after surgery. The immediate Post-Operative Note should contain the patient condition, estimated blood loss if any, pre and post operative diagnosis and procedures, the name of the primary surgeon including any assistants, and specimens removed.

6.16 The Director of Surgical Services or designee shall have the authority to delay any surgical case when, in his/her opinion, consultation with the Chair of Surgery and/or Medical Staff President is deemed to be advisable.

ARTICLE VII
SPECIAL RULES REGARDING DENTISTRY/ORAL SURGERY AND PODIATRY

7.1 A patient admitted for dental care or podiatry is a dual responsibility involving the dentist or podiatrist and physician member of the medical staff, except in those circumstances where the dentist or podiatrist has certification in oral or podiatric surgery, respectively.

A physician member of the 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 and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. Except in the event of an emergency, the responsible physician member shall be identified prior to admission of the patient for surgery to be performed by a dentist or podiatrist staff member.

7.2 Complete records, both dental or podiatric and medical, shall be required on each patient. The dentist or podiatrist shall be responsible for the dental or podiatric portion, respectively, of the record while the physician shall be responsible for the medical portion.

In the case where a dentist or podiatrist has certification which includes training and experience in history taking and physical evaluation of the patients, the dentist or podiatrist as appropriate may perform the H & P without a dual admission.

ARTICLE VIII
GENERAL RULES REGARDING EMERGENCY SERVICES

8.1 A medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record as appropriate.

8.2 Initial Screening of Emergency Services Patients - All patients presenting in Emergency Services will be evaluated by a triage nurse acting under the direction of the Emergency Services physician on duty. The nurse will report his/her findings promptly to the Emergency Services physician, who will provide the physician's assessment and determine the appropriate medical intervention or disposition. Any standing protocols applicable to a patient arriving in Emergency Services, e.g., Advanced Trauma Life Support, Pediatric Life Support or Advanced Cardiac Life Support will be initiated by personnel appropriately certified. If a physician is not physically present in the Emergency Services Department at the time an individual is to be transferred to another facility, then the Emergency Services Charge Nurse from the transferring facility must sign the appropriate transfer certification form, including the risks and benefits, after consultation with and agreement by the physician. The same physician must subsequently countersign the certification form.

8.3 There shall be a monthly review of emergency room medical records by the Emergency Services physicians and by appropriate review personnel to evaluate quality of emergency medical care and compliance with EMTALA.

8.4 There shall be a plan for the care of mass casualties at the time of the major disaster based upon the Medical Center's capabilities.

a. Medical Staff members shall be assigned to casualty posts (stations) as determined by the Disaster Plan for the Cape County Medical Society. The Chair of Clinical Services and the President/CEO of the Medical Center shall work together as a team to coordinate activities and directions.

b. The disaster plan should be rehearsed yearly as part of a coordinated drill in which other community emergency service agencies participate. There should be a written report and evaluation of all drills.

8.5 Medical staff membership carries with it the responsibility to attend, care and treat Emergency Services patients when notified by the Emergency Department physician.

a. Medical Staff members upon attaining the age of 60 years are no longer required to participate in Emergency Room Call.

b. Call for patients presenting with “no local physician” will be on a rotating schedule prepared by the Cape Girardeau County Area Medical Society.

c. Failure of Medical Staff members to accept assignments and emergency call as provided herein, without just and reasonable cause or substitution shall be cause for corrective action under the Medical Staff Bylaws. Medical Staff members must give thirty (30) days advance notice of intent to resign from the emergency call rotation or make arrangements for coverage of already assigned emergency call dates.

d. After the initial medical screening examination, the Emergency Department physician, at his/her discretion, may consult with the patient’s attending physician, if known, to obtain medical information necessary to determine the appropriate evaluation and treatment of the patient. If, after an initial medical screening examination, the Emergency Department physician determines that the patient requires the services of an On-Call physician to complete the evaluation and/or stabilize the patient, the Emergency Department physician/Registered Nurse will contact the On-Call physician,

who shall present to the Emergency Department within a reasonable time. Failure to report will be a violation of the Medical Staff Rules and Regulations and subject to disciplinary action under the Medical Staff Bylaws of Saint Francis Medical Center.

e. Disagreements: In the event of a disagreement between the Emergency Department physician and the On-Call physician, the opinion of the Emergency Department physician shall prevail until the On-Call physician comes to the Emergency Department and examines the patient.

ARTICLE IX
ANESTHESIA SERVICES PRIVILEGES

9.1 The Section of Anesthesiology, under the direction of the Section Chair, shall govern the provision of all anesthesia services provided in the hospital.

9.2 Anesthesia services include the following categories: general anesthesia, regional anesthesia, monitored anesthesia care (includes deep sedation), moderate sedation/analgesia ("conscious sedation"), topical or local anesthesia, and minimal sedation.

9.3 Appropriate privileges are required for each level of anesthesia services (see below), including sedation and monitored anesthesia care. Training and/or experience must be documented for Level I and II privileges; such privileges may be granted by the department in which the practitioner resides, provided the Section Chair of Anesthesiology has approved the privileging process and criteria.

Level I
Granted to those members of or applicants to the Medical Staff or other practitioners who are permitted to perform local infiltration anesthesia, topical application, minor nerve blocks or moderate sedation/analgesia.

Level II
Granted to those members of or applicants to the Medical Staff and other practitioners who are qualified through documented training and/or experience to perform more complex anesthetic procedures. Examples include epidural analgesia, IV regional blocks, major peripheral nerve blocks, and retrobulbar blocks.

Level III—General Privileges in Anesthesia
These privileges are granted to physicians or certified registered nurse anesthetists who are qualified to render patients insensible to pain and emotional stress during surgical, obstetrical, and certain medical procedures using general anesthesia, regional anesthesia and/or parenteral sedation to a level at which a patient's reflexes may be obtunded. The performance of preanesthetic, intra-anesthetic and post anesthetic evaluation and management and appropriate measures to protect life and functions and vital organs are required.

Level IV—Invasive Anesthesia Privileges - Pain Management
These privileges are granted to physicians who are qualified to perform placement of implantable (long term) epidural and subarachnoid catheters, electrical stimulation devices and neurolytic procedures. Privileges will be based on verification of training through residency or fellowship or an acceptable course including hands-on training.

9.4 The Board must approve the specific anesthesia service privileges for each practitioner who furnishes anesthesia services and shall address the type of supervision, if any, required.

ALL DATES ON THIS PAGE SUBJECT TO REVISION
THESE RULES AND REGULATIONS OF THE MEDICAL STAFF

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 10th Day of Sept., 2002.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 19th DAY OF September, 2002.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 2nd Day of Dec., 2003.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 3rd DAY OF December, 2003.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 6th Day of June, 2006.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 14TH DAY OF SEPTEMBER, 2006.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 11th Day of SEPT., 2007.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 13TH DAY OF SEPTEMBER, 2007.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 8th Day of JAN., 2008.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 10TH DAY OF JANUARY 2008.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 7TH Day of APRIL, 2009.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 16TH DAY OF APRIL, 2006.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 14th Day of SEPT., 2010.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 28TH DAY OF SEPTEMBER, 2010.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 4th Day of JAN., 2011.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 13th – Day of JANUARY, 2011.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 6th Day of DEC., 2011.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 8th – Day of DECEMBER, 2011.

REVIEWED AND APPROVED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE THIS 7th Day of JAN., 2014.

REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS THIS 16th – Day of JANUARY, 2014.