# LUCAS COUNTY HEALTH CENTER
## Chariton, Iowa

# MEDICAL STAFF BYLAWS

Restated Bylaws Adopted July 30, 2019

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# MEDICAL STAFF BYLAWS

## I. PREAMBLE

Hospital a governmental institution that is operated by the Board of Trustees organized under the laws of the State of Iowa. The hospital exists to offer general inpatient and outpatient hospital care, related health care services, patient and community education, and other services which promote the general health of citizens in the area.

The Board of Trustees of the Hospital is responsible for management and operation of the Hospital. However, an organized medical staff is in a special position to initially assess and monitor the quality of care and the qualifications and practices of the individual providers who comprise that medical staff, and to assist in regulating the programs, activities, and practices of all health care personnel practicing within the Hospital. The Board of Trustees necessarily delegates to the Medical Staff certain initial responsibility for medical care and peer review within the Hospital, with the understanding that such delegated responsibility will be exercised in pursuit of the legitimate purposes of the Hospital and the Medical Staff, in cooperation with the Chief Executive Officer (CEO) of the Hospital, and under the ultimate authority of the Board.

Therefore, the Chief Executive Officer, Board of Trustees, and the Medical Staff are organized in conformity with these bylaws.

## II. DEFINITIONS

A. **"Advanced Practice Provider"** shall be interpreted as, unless otherwise expressly limited, a nurse practitioner or physician assistant who is applying for Affiliate Medical Staff membership and/or clinical privileges, or who is an Affiliate Medical Staff member and/or who exercises clinical privileges in the Hospital.

B. **"Board" or "Governing Body"** shall be interpreted as the Hospital Board of Trustees.

C. **"Chief Executive Officer" (CEO)** shall be interpreted as the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

D. **"Clinical Privileges" or "Privileges"** shall be interpreted as the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatry, or surgical services.

E. **"Ex Officio"** shall be interpreted as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

F. **"Hospital"** shall be interpreted as Hospital currently operating as a Critical Access Hospital.

G. **"Medical Executive Committee"** shall be interpreted as the executive committee of the Medical Staff.

H. **"Medical Staff"** shall be interpreted as all licensed Doctors of Medicine, Doctors of Osteopathy, advanced practice providers, and other specialty physicians who are granted clinical privileges in the Hospital.

I. **"Medical Staff President"** shall be interpreted as the Medical Staff President.

J. **"Medical Staff Year"** shall be interpreted as the period from July 1 to June 30.

K. **"Patient Contacts"** shall be interpreted as any inpatient acute or inpatient skilled admissions.

L. **"Physician"** shall be interpreted as, unless otherwise expressly limited, a Doctor of Medicine or Doctor of Osteopathy, dentist, or podiatrist who is applying for Medical Staff membership and/or clinical privileges, or who is a Medical Staff member and/or who exercises clinical privileges in the Hospital.

M. **"Prerogative"** shall be interpreted as participatory right granted by virtue of staff category or otherwise to a staff member or affiliate and exercisable, subject to the conditions imposed in these bylaws and in other Hospital and Medical Staff policies.

N. **"Provider"** shall be interpreted as a term used generically for all physicians and advanced practice providers.

O. **"Special Notice"** shall be interpreted as written notification sent by certified or registered mail, return receipt requested.

## III. MEDICAL STAFF APPOINTMENT

**A. Nature of Appointment:** No licensed Doctor of Medicine or Osteopathy, advanced practice provider, dentist, podiatrist or other specialty physician shall admit or provide medical or health-related services to patients in the Hospital unless he or she has been appointed to the Medical Staff or has been granted temporary privileges pursuant to the Appointment and Corrective Action Procedures. Appointment to the Medical Staff shall confer upon the Medical Staff appointee a privilege in the nature of a license to exercise only such clinical privileges within the Hospital as are specifically granted by the Board in accordance with these Medical Staff Bylaws and the Appointment and Corrective Action Procedures. A Medical Staff appointee is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Medical Staff appointee. In the event of a conflict between the language of these Medical Staff Bylaws or the Appointment and Corrective Procedures or Fair Hearing Procedure and a specific contract between the Hospital and a Medical Staff appointee, the language of the contract shall control. The Board of the Hospital retains the right to make final decisions and to initiate action when required to protect patients of the Hospital, preserve the quality of care, and protect the Hospital or its Medical Staff. The procedures specified in these Medical Staff Bylaws shall not preclude the Board from taking any direct action authorized under the Board's bylaws, policies and/or procedures.

**B. Small Active Staff:** It is recognized that Hospital is a small hospital with a small medical staff. The committees and procedures set forth in these Bylaws shall therefore be permitted flexibility, and the Medical Staff, CEO and Board shall be permitted latitude in applying these Bylaws, to the extent reasonably necessary so that the fundamental purposes of the Medical Staff and of these Bylaws may be carried out. Without limitation, this flexibility and latitude shall mean that:

a. An Active Staff member may hold more than one (1) office, or members from other staff categories may be allowed to vote or hold office or carry out other functions normally handled by the Active Staff, upon approval of the Board for specified periods, whenever there are fewer than three (3) Active Staff members in good standing;

b. Matters normally handled by the Medical Staff may, when necessary, be referred to the Board for handling, with the approval of the Board or upon assumption of duties by the Board under Article X.

c. The CEO, Hospital administrative staff or professional staff, advanced practice providers or others may serve on Medical Staff or interdisciplinary committees, with or without vote, by appointment of the Medical Executive Committee or the Board.

The Medical Staff, Board and Hospital shall be deemed to have complied with these Bylaws whenever action is taken in good faith, in the interest of serving the stated purposes, and in a manner appropriate to the personnel and resources then available. To the extent necessary to fulfill the purposes set forth above, this Article shall override any contrary or inconsistent provisions contained elsewhere in these Bylaws.

**C. Time Periods:** All time periods referred to in these Bylaws for action by committees or panels of the Medical Staff, the CEO or the Board, and references to meetings at which action should be taken by them, are advisory only and not mandatory. While no such actions shall be required to be accomplished in less time than specified, extensions may be granted or permitted for reasonable cause or the convenience of the participants. Time periods within which individual providers are permitted to request a hearing or an appellate review, or to take other action, are intended to impose mandatory limitations and shall be strictly construed absent agreement to the contrary. Any time period set forth in these Bylaws may be changed by agreement of all of the parties affected.

**D. Responsibilities of Medical Staff Appointees:** Each appointee of the Medical Staff shall:

1. Exercise 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 an appropriate alternative for such care and supervision;

2. Provide his/her patients with the quality of care meeting generally recognized professional standards;

3. Participate in the medical care of indigent patients, and not deny care on the basis of sex, race, age, sexual orientation, gender identity, creed, color, national origin, disability, or other criteria unrelated to delivery of quality care;

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

5. Abide by the ethical principles of his/her profession;

6. Maintain and verify professional liability coverage;

7. Promptly report his/her involvement in and the on-going status of any professional liability action to the Medical Staff President;

8. Promptly report any imposition of a suspension, limitation, revocation or adverse action affecting licensure, registration, certification, qualification to participate and/or privileges granted by a medical licensing or certification body or other health care institutions or exclusions from any governmental programs such as Medicare or Medicaid to the Medical Staff President; and

9. Abide by the Medical Staff Bylaws and all appendices to these Medical Staff Bylaws, including the credentialing and privileging manual, the Rules and Regulations, and Hospital Bylaws and policies.

**E. Medical Staff Membership:** Membership on the Medical Staff, including assignment to one of the staff categories described in Article IV, is granted by the Board following recommendation of the Medical Staff. Application for or acceptance of membership constitutes acceptance of responsibility to participate in the affairs of the Medical Staff, to perform assigned responsibilities, to work in aid of the purposes of the Medical Staff and the Hospital, and to be governed by these Bylaws and the Bylaws of the Hospital. Each member and each applicant for membership must, as a continuing condition of and for membership, hold or be legally eligible and qualified under these Bylaws for consideration for clinical privileges of the Hospital, including either admitting or co-admitting privileges.

**F. Non-Discrimination:** Medical Staff appointment or particular clinical privileges shall not be denied on the basis of sex, race, age, sexual orientation, gender identity, creed, color, national origin or disability or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

**G. Appointment and Privileging**

**1. Application for Appointment or Clinical Privileges**

Appointment to the Medical Staff of the Hospital is a privilege that shall be extended only to competent professionals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and the Hospital.

All applications for membership or clinical privileges must be in writing, signed by the applicant, and submitted on a form prescribed by the Hospital with the advice of the Medical Executive Committee, indicating the category of membership and the particular clinical privileges requested. The applicant has the burden of producing adequate information and documentation for a proper evaluation of the application. The application form shall contain the applicant's agreement to be bound by the terms of the Hospital's Bylaws and the Medical Staff Bylaws and rules and regulations in all matters relating to consideration of the application (whether or not the application is acted upon favorably), and in all matters pertaining to his/her practice at the Hospital if granted membership and privileges.

## 2. Appointment Process

The completed application must be submitted to the CEO or the CEO's designee. The CEO or the CEO's designee will review the application for completeness and verify the references, licenses and other information submitted. The National Practitioner's Data Bank will also be queried. The CEO or designee will promptly inform the applicant if the application is incomplete or there are any problems in verifying the information contained in the application and it shall be the applicant's obligation to obtain and furnish the required information. If the required information is not received by the CEO or designee within sixty (60) days thereafter, the application will be deemed withdrawn, and the applicant will be so informed by the CEO. When collection and verification is satisfactorily accomplished, the CEO or designee will assemble the application and all supporting materials and transmit them to the Medical Executive Committee. The CEO need not accept or forward to the Medical Executive Committee, and the Hospital and the Medical Staff need not act on, an application by an individual who is not eligible under these Bylaws; or an application for clinical privileges which are not available at the Hospital due to lack of appropriate facilities, provision of such services by the Hospital itself or under exclusive contract, or for other reasons.

## 3. Investigation

Upon receipt of the completed application and supporting materials, the Medical Executive Committee may conduct any investigation it deems necessary and appropriate or may appoint an individual provider or an ad hoc committee to assist in an investigation of the applicant. When the applicant is a non-physician, the advice of another member of the applicant's profession may be sought as to the applicant's apparent qualifications to exercise the privileges requested. The Medical Executive Committee may also meet personally with the applicant and may seek advice from the CEO or any other source when the Medical Executive Committee deems it helpful to do so in considering an application.

## 4. Medical Executive Committee Review

Within sixty (60) days after receipt by the Medical Executive Committee of the completed application and supporting materials from the CEO or designee, the Medical Executive Committee shall transmit to the CEO a written report of its recommendation that the applicant be either appointed to the Medical Staff and granted privileges, or denied Medical Staff membership and clinical privileges, or the Medical Executive Committee may defer the application for up to thirty (30) additional days for further consideration. A recommendation for appointment and privileges must include the category of Medical Staff, specific privileges and any limitations thereon. The Medical Executive Committee may also advise the CEO and the Board on any novel issues or matters of special concern presented by the application.

## 5. Notice of Recommendation and Subsequent Action.

a. Upon receipt of the Medical Executive Committee's favorable recommendation, the CEO will promptly forward the recommendation to the Governing Board for action.

b. Upon receipt of the Medical Executive Committee's adverse recommendation, the CEO will notify the applicant of the nature of the recommendation. If the recommendation is one for which the applicant may request a hearing under these Bylaws, the CEO shall also provide the applicant with the information described in Article XV and shall take no further action for thirty (30) days. If the applicant requests a hearing within thirty (30) days, the recommendation regarding appointment and/or privileges will not be forwarded to the Board, and the procedures set forth in Article XV of these Bylaws will apply. If the recommendation is not one for which the applicant may request a hearing, or if no hearing is requested within thirty (30) days after notice of the recommendation, the CEO will transmit the recommendation to the Board for final action.

**6. Board Action.**

At its next regular meeting following receipt of the Medical Executive Committee's recommendation (or at a special meeting called for this purpose), the Board will act on the matter. In its discretion, the Board may defer action for a specified period of time, during which time it may refer the matter back to the Medical Executive Committee for specified further action or seek advice from the CEO, legal counsel or others on matters of concern. The Board's decision shall be final and conclusive, except that if the Medical Executive Committee's recommendation was one for which the applicant could not request a hearing, and the Board's decision is contrary to the Medical Executive Committee's recommendation and one for which the right to hearing is provided in these Bylaws, the applicant may request a hearing under Article XV. The applicant and the President of the Medical Staff will be promptly notified of the decision of the Board.

**7. Duration of Appointment.**

Each regular appointment or reappointment to the Medical Staff and each grant of privileges will be for a period of two (2) years, terminating at the end of the Medical Staff year, or as soon thereafter as the Board considers reappointment of Medical Staff members, unless earlier terminated, suspended or limited in accordance with these Bylaws.

## H. Reappointment/Renewal Process

1. Each provider with clinical privileges at the Hospital must submit a signed, completed application for reappointment and renewal of privileges to the CEO every two (2) years.

   Failure to submit a completed application by no later than sixty (60) days before the end of the two (2)-year appointment period may be considered a voluntary resignation from the Medical Staff and a relinquishment of clinical privileges at the end of the Medical Staff year.

2. The CEO or the CEO's designee will verify that the application is complete, notify the applicant of any further information which is required and obtain any other materials deemed pertinent to consideration of the application. The CEO or designee will then transmit copies of the completed application and all supporting materials to the Medical Executive Committee. Thereafter, the procedures set forth in Article III,

Section G.2., will apply, except that the Medical Executive Committee will generally complete its review and transmit its recommendation within thirty (30) days (rather than sixty (60) days on initial appointment applications).

3. In reviewing applications for reappointment and renewal of privileges, the Medical Executive Committee and Board will not be limited to review of information supplied within or in support of the application but may review and consider any other records and information deemed relevant to their review. Without limitation, this may include review of such items as Board, Medical Staff or committee meeting minutes or records; utilization review, peer review, and quality assurance records and reports; patient charts; incident reports; records of civil malpractice proceedings; insurance documents; records of the Iowa Board of Medicine or other governmental agencies; personal medical records of the applicant; complaints or comments from other members of the Medical Staff or of the Hospital Staff, the CEO, patients or members of the public; and any other relevant documents or information. The Medical Executive Committee and Board may also consider whether the provider has actually exercised all of the requested privileges with sufficient frequency since the time of last appointment or reappointment to indicate current proficiency.

4. Unless otherwise modified, suspended or revoked under these Bylaws, upon receipt of a complete, timely application for reappointment, the existing membership and privileges will remain effective until final action by the Board.

## I. Application Following Adverse Decision

No application for Medical Staff membership or clinical privileges will be received or processed if, within the prior twelve (12) months, the applicant has been denied membership or denied the same or similar privileges at the Hospital, or has had his/her membership or the same or similar privileges revoked, unless the Medical Executive Committee determines in its sole discretion that there is good cause under the circumstances of the particular case for considering the application. In such cases, the CEO will notify the applicant as to whether or not the application has been received and will be processed.

## J. Appointment and Privileging of Telemedicine Medical Staff

Telemedicine is the use of medical information exchanged from one site to another via electronic communication for the purpose of patient care, treatment and services. The Telemedicine Staff shall consist of physicians who will be providing patient care, treatment and services only through telemedicine and who have been granted privileges by the medical staff and governing body of another Medicare certified hospital or telemedicine entity (a "Distant Site Hospital or Telemedicine Entity") with which the Hospital has a written telemedicine services agreement that meets applicable regulatory requirements and provides for delegated credentialing. For all Distant-Site Hospital or Telemedicine Entity physicians that will provide telemedicine services under the agreement, the Distant-Site Hospital or Telemedicine Entity's medical staff and governing body will be responsible for (i) conducting an evaluation of each physician's licensure and qualifications pursuant to the provisions of the Distant-Site hospital or Telemedicine Entity's medical staff and hospital bylaws, rules and regulations, and granting membership and clinical privileges at the Distant-Site Hospital or Telemedicine

Entity in accordance with those provisions, (ii) providing Hospital with a list of those physicians covered by the agreement that includes the licensure information and clinical privileges that have been granted to each physician; (iii) providing Hospital with an updated list of physicians covered by the agreement when necessary to reflect additions, deletions and changes. Upon receipt from the Distant-Site Hospital or Telemedicine Entity of the information required by this Section, each physician may be admitted as a member of the Telemedicine Staff and granted clinical privileges. A physician who has his privileges limited or terminated at a Distant Site Hospital or Telemedicine Entity will have his privileges similarly limited or terminated at Hospital without a right of hearing or appeal under these Bylaws. Upon termination of the telemedicine services agreement or delegated credentialing/privileging agreement between Hospital and the Distant Site Hospital or Telemedicine Entity, all Telemedicine Staff providing services pursuant to the terminating agreement will have their staff membership and privileges automatically terminated without the right to hearing or appeal under these Bylaws.

Telemedicine privileges shall coincide with the privileges granted by the Distant Site Hospital or Telemedicine Entity to the extent applicable at Hospital. All telemedicine providers will be categorized as "telemedicine staff" and will not be eligible to vote, hold office or be required to pay medical staff dues or follow other medical staff or hospital requirements for providers that provide direct patient care (e.g., requiring TB immunizations, etc.).

**K. Temporary Privileges.**

Temporary privileges as defined, limited, and conditioned below may be granted to individuals who would be eligible for regular privileges under the terms of Article V, in the following circumstances:

a. **Requirements.** Temporary privileges may be granted to permit the individual to attend patients in the Hospital, provided that:

(1) If temporary privileges are granted to an applicant for regular privileges whose application is pending, such temporary privileges shall immediately terminate, if not sooner, if and when the Medical Executive Committee recommends that the application for regular privileges be denied.

(2) In all other cases (except locum tenens coverage), no individual may be granted temporary privileges for more than sixty (60) days at the Hospital during any calendar year.

Temporary privileges may be granted to accommodate a locum tenens coverage arrangement for an individual with regular privileges, but no individual shall hold locum tenens temporary privileges for more than sixty (60) practice days in any calendar year.

b. **Nature.** Temporary privileges constitute temporary permission to engage in a limited practice in the Hospital. Temporary privileges are distinguished from regular privileges at the Hospital in that they are granted only for the temporary convenience of the patients. Temporary privileges may be granted by the CEO after consultation with the President of

the Medical Staff.

c. **Conditions.** All individuals with temporary privileges shall maintain insurance as required in Article V; shall respect and abide by all conditions imposed upon providers holding regular privileges at the Hospital; and may be subject to further conditions and limitations imposed by the CEO after consultation with the President of the Medical Staff.

d. **Revocation.** Temporary privileges may be revoked at any time by the CEO. In addition, whenever it is believed that the life or health of a patient would be endangered by continued treatment by an individual with temporary privileges, those privileges may be immediately revoked by the President of the Medical Staff or the Medical Executive Committee. Any permission or right to practice pursuant to temporary privileges expires upon revocation or expiration of temporary privileges, without recourse to the hearing and appeal procedures of Article IX, or any other recourse.

e. **Acceptance of Terms.** Acceptance of the terms and provisions of this section is an express condition of applying for, receiving, or exercising temporary privileges.

**L. Emergency Privileges.**

For the purposes of this section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death, and any delay in administering treatment would add to that danger. In the case of a medical emergency, any provider who would be eligible for membership or privileges by virtue of licensure, may be permitted and assisted to attend and treat the patient within the scope of his or her licensure, using the facilities of the Hospital, without regard to staff status or lack thereof, provided that no member of the Medical Staff with appropriate privileges to treat the patient is immediately available. When an emergency situation no longer exists, all emergency privileges expire, and the provider may request temporary privileges to continue to treat the patient. As soon as practical, the patient shall be assigned to a member of the Medical Staff with admitting privileges.

The emergency privileges available under this Section are not clinical privileges of the Hospital. They are exclusively for the benefit of the patient.

**M. Co-Admitting Privileges.**

Co-admitting privileges are a clinical privilege of the Hospital granted to qualified providers the same as any other privileges. Co-admitting privileges entitle the provider to admit a patient to the Hospital for treatment within such individual's area of licensure, subject to designating a member of the Medical Staff with admitting privileges who is willing to assume responsibility for medical evaluation, patient's course of care in the Hospital. The provider with co-admitting privileges shall be responsible for making suitable arrangements with the Medical Staff member designated, to assure prompt medical evaluation and assumption of responsibility of each patient admitted. In order to be eligible for co-admitting privileges, the provider must meet all of the criteria for clinical privileges of the Hospital; be licensed in a health care specialty which is authorized to diagnose and treat conditions which regularly require hospitalization; and meet such other conditions as are recommended by the Medical Staff and approved by the Board.

**N. Admitting Privileges.**

Admitting privileges are a clinical privilege of the Hospital, granted to qualified providers in the

same manner as other privileges. In order to be eligible for admitting privileges, the provider must:

a. Meet all of the criteria for clinical privileges of the Hospital.

b. Be licensed in a health care specialty which is authorized to diagnose and treat conditions which regularly require hospitalization.

c. Be licensed in such a manner that inpatient Hospital care, including overnight hospitalization, ancillary services, tests, pharmaceutical agents, and supplies, ordered and certified to by such provider, will be recognized as medically necessary and reimbursable under Medicare, Medicaid, Blue Cross, and other payment programs.

d. Be authorized by law to prescribe or approve medications which patients may bring with them into the Hospital.

e. Be authorized by licensure to independently perform medical evaluation, including a history and physical examination, and to assume overall responsibility for a patient's care in the Hospital.

f. Practice his or her profession within 60 minutes of the Hospital to assure that any patient admitted by them will receive continuous care.

g. Meet such other conditions as are adopted by the Medical Staff and approved by the Board.

## IV. CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be granted by the Board and shall be to one of the following categories. The staff categories for physicians shall include active, courtesy, affiliate, consulting, and telemedicine. Advanced practice providers will be appointed to the Affiliate Staff.

### A. Active Staff

1. The Active Staff consists of physicians who meet all of the criteria for clinical and admitting privileges, who regularly admit and attend patients at the Hospital, who are available to provide appropriate and timely care to patients taking into consideration the patient's condition, and who are authorized by law and this Hospital and its Medical Staff to assume and perform the responsibilities attendant to Active Staff membership. The Active Staff shall be primarily responsible for achieving the purposes of the Medical Staff, including, where appropriate, emergency care and consultation assignments; for executing delegated responsibility of the Board; and for performing the required functions of the Medical Staff. Members of the Active Staff are eligible to vote and hold office, are eligible to serve on all committees and shall serve on the Medical Executive Committee.

2. Physicians who are members of the Active Staff may admit patients without limitation and treat patients within the limits of their assigned clinical privileges.

### B. Courtesy Staff

1. The Courtesy Staff consists of physician who wish to occasionally admit or co-admit patients to the Hospital, or wish to refer patients for certain Hospital diagnostic or ancillary services such as lab,

X-ray or pharmacy, but who do not wish to become members of the Active Staff or who are not eligible for such appointment; and includes emergency physicians working under contract with the Hospital, dentists, and podiatrists. Physicians who have more than thirty-five (35) patient contacts during any Medical Staff year may be required to apply for Active Staff membership, and shall be considered ineligible to obtain or to continue Courtesy Staff membership, unless the Medical Executive Committee and the Board concur with the member that the interests of the Medical Staff and the Hospital would be best served by allowing the member to serve on the Courtesy Staff. Members of the Courtesy Staff must secure the concurrence of a member of the Active Staff who may be called in to see inpatients when the Courtesy Staff member is not immediately available.

2. At times of full Hospital occupancy or shortage of Hospital beds or other resources, as determined by the CEO in consultation with the Medical Staff President, the elective patient admissions of Courtesy Staff members shall be subordinate to those of Active Staff members.

**C. Affiliate Staff**

1. The Affiliate Staff consists of those providers who hold clinical privileges at the Hospital, who regularly co-admit, admit, or attend patients at the Hospital, and who are located close enough to the Hospital or who otherwise arrange to provide continuous care to their patients. Affiliate Staff may include, but is not limited to CRNA's, ARNP's, and PA's. A Physician Assistant (PA) may be granted privileges with his/her supervising physician who must also have medical staff privileges at the Hospital. Advanced practice providers may perform only such functions as approved by the Medical Staff and Board.

2. With the concurrence of the Active Staff, the Affiliate Staff may hold meetings in joint session with the Active Staff.

**D. Consulting Staff**

1. The Consulting Staff consists of physicians who are recognized specialists willing to serve in a consulting capacity. Members of the Consulting Staff shall provide their services in the care of patients whenever reasonably possible on request of any member of the Active, Affiliate or Courtesy Staff.

2. Members of the Consulting Staff generally will not have independent admitting privileges.

**E. Telemedicine Medical Staff**

1. Telemedicine is the use of medical information exchanged from one site to another via electronic communication for the purpose of patient care, treatment and services. Individuals providing telemedicine services from a "distant site" must be appointed to the Telemedicine Staff in accordance with Section J above, unless the telemedicine service is provided in conjunction with a licensed provider at the hospital who is responsible for the patient's care.

2. All telemedicine providers will be categorized as "telemedicine staff" and will not be eligible to vote, hold office or be required to pay medical staff dues or follow other medical staff or hospital requirements for providers that provide direct patient care (e.g., requiring TB immunizations, etc.).

### F. Meetings and Responsibilities

1. Members of the Courtesy, Consulting, and Affiliate Staffs may attend the Medical Staff meetings if invited. Members of the Affiliate, Courtesy, and Consulting Staffs may be appointed to Medical Staff committees, and when so appointed shall perform all assigned responsibilities.

2. Only members of the Active Staff shall be eligible to vote on any action of the Medical Staff, except that when appointed to committees of the Medical Staff, all members of the Medical Staff shall be permitted to vote on matters coming before such committees, unless such permission is expressly withheld under the terms of their committee appointments or these Bylaws.

3. Members of the Active Staff shall attend not fewer than fifty percent (50%) of the Active Staff meetings and of all committees to which they are assigned each Medical Staff year, including the annual meeting of the Medical Staff.

4. Members of the Affiliate, Courtesy, and Consulting Staffs, when appointed to committees, shall attend not fewer than fifty percent (50%) of meetings of such committees each Medical Staff year.

## V. CLINICAL PRIVILEGES

### A. Acceptance of Privileges

Privileges to practice at the Hospital are granted by the Board following recommendation of the Medical Staff. Application to or acceptance and exercise of privileges constitutes acceptance of the terms and conditions of these Bylaws and the Bylaws of the Hospital. The prerogatives attendant to holding privileges in this Hospital are expressly limited by the provisions of these Bylaws and the Bylaws of the Hospital. A provider may exercise only those clinical privileges specifically granted in accordance with these Bylaws.

### B. Qualifications

The following constitute continuing qualifications for the exercise of privileges at the Hospital. Each member and applicant for membership and clinical privileges shall:

1. **Licensure:** Be currently licensed by the State of Iowa to practice his/her profession and to exercise the clinical privileges held or applied for; and be currently registered by the federal Drug Enforcement Administration (D.E.A.) to prescribe drugs consistent with the clinical privileges held or applied for;

2. **Competence:** Possess and maintain demonstrated clinical competence, including current knowledge, judgment and technique in his/her specialty area and for all privileges held or applied for;

3. **Nature of Practice:** Practice a branch of health care or a specialty which is consistent with the purposes, treatment, philosophy, methods and resources of the Hospital and for which the Hospital has a current need;

4. **Education, Training, and Competence**: Demonstrate satisfactory formal education and training commensurate with the privileges applied for and consistent with departmental requirements; if applicable, demonstrate evidence of completion of a postgraduate clinical residency or fellowship in a relevant specialty which is conducted in whole or in substantial part in a hospital setting and

which is accredited or approved by the appropriate national board. Foreign medical school graduates must be certified by the Educational Council for Foreign Medical School Graduates. Possess demonstrated current competence, including current knowledge, judgment and technique in his/her field or specialty area;

5. **Ethics:** Strictly abide by the ethics of his/her profession and avoid acts and omissions constituting unprofessional conduct under applicable state licensing laws and regulations. Avoid conduct which reflects adversely on professional fitness (or findings that such conduct has occurred, or sanctions based on such conduct). This includes all conduct deemed unethical, conduct considered unprofessional under state licensing authority, conduct subject to sanction under Medicare or fraud and abuse guidelines, conduct subjecting the provider to exclusion under Medicare/Medicaid or other state or federal reimbursement schemes, and conduct subject to criminal sanction;

6. **Health Status:** Be free of, or have under adequate control, any significant physical, mental or behavioral impairment that interferes with, or presents a substantial probability of interfering with patient care, the exercise of privileges, the assumption and performance of required responsibilities, or cooperative working relationships. Cooperate openly and fully in any required health assessment;

7. **Professional Liability Coverage:** Maintain in full force and effect valid coverage for personal professional liability in any amount not less than $1 million/$3 million and document such coverage to the satisfaction of the Hospital by providing a copy of the current certificate of insurance;

8. **Cooperation with Peer Review:** Cooperate in any review of his/her (or another's) credentials, qualifications or compliance with these Bylaws and refrain from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities, or otherwise;

9. **Compliance with Bylaws, Rules, and Regulations**: Abide by the terms, conditions and procedures of these Bylaws and the rules and regulations of the Medical Staff, together with the Bylaws and governing policies and procedures of the Hospital insofar as applicable to the provider;

10. **Responsibilities:** Carry out assigned patient care, committee and staff responsibilities consistent with the provider's membership. Demonstrate the ability to work cooperatively and professionally with the Hospital, its professional staff and the Medical Staff, and refrain from disruptive behavior which could interfere with patient care or the operation of the Hospital and its Medical Staff;

11. **Quality and Utilization Management:** Work cooperatively with the Quality and Risk Management Committee, the Utilization Review Committee, Medical Executive Committee and administration to meet and practice within the guidelines established by the Hospital, minimize or eliminate disallowed admissions, order and utilize supporting and ancillary services only when necessary, and minimize medically unnecessary lengths of stay at the Hospital;

12. **Information:** Provide accurate, current and complete information in connection with the appointment, reappointment and privileging process, or in response to inquiries from the Medical Executive Committee or the Board; and immediately report (within ten (10) days of entry or occurrence of any of the following occurrences: (i) judgment, settlement or compromise in a professional liability action resulting in payment in excess of $10,000 by or on behalf of the provider; (ii) action limiting or suspending the provider's license to practice a profession or his/her state or federal authority to prescribe medications; (iii) exclusion from the Medicare or Medicaid

program; (iv) cancellation of professional liability coverage used to satisfy the financial responsibility criterion for privileges; or (v) loss or significant curtailment of privileges at another health care facility;

13. **Antidumping and Indigent Care Requirements:** Upon request of the Hospital or its Medical Staff, provide appropriate and necessary emergency or non-emergency medical treatment within the scope of such provider's privileges to any patient seeking such treatment, regardless of such patient's ability to pay;

14. **Confidentiality:** Maintain the confidentiality of patient clinical information and of the minutes, records and work product of Medical Staff committees engaged in the peer review process. This provision shall not prohibit mandatory disclosures under state or federal law, nor disclosures made in the context of peer review;

15. **Records:** Complete all required patient care records in a thorough, professional and timely fashion. Records must be completed no later than 30 days after patient discharge or encounter;

16. **Documentation:** Document each of the foregoing qualifications to the satisfaction of the Board and Medical Staff. The provider shall have the burden of establishing that he/she meets all eligibility requirements, qualifications and conditions for the exercise of privileges.

The foregoing qualifications shall not be deemed exclusive if other qualifications and conditions are also relevant to considering an applicant or granting or exercising privileges in the Hospital. In considering an applicant for privileges, the Medical Staff and Board may also consider the ability of the Hospital to provide adequate facilities in support of services for the applicant and his/her patients; the needs of the Hospital for Medical Staff members with the applicant's skill and training; the intent of the Hospital to provide certain services through its employees or contractors; and the long range plans of the Hospital with respect to the emphasis or de-emphasis of particular specialties and the opening, closing or purchase of specific services, resources and capacity.

## VI. CHANGES IN STATUS UNDER CONTRACTS; LEAVES OF ABSENCE

A. **Changes in Contracts or Other Arrangements:** Certain providers may provide administrative and/or patient care services under contract, employment or other separate arrangement with the Hospital. In such cases, the parties may agree to provisions which differ from these Bylaws, and to that extent these Bylaws may be inapplicable. For example, the contract, employment or other arrangement may provide that upon termination the provider will be deemed to have resigned from the Medical Staff or relinquished all or part of his or her clinical privileges or practice authority, without any right to hearing, appeal, or other procedures. Such an agreement will be binding notwithstanding anything to the contrary contained elsewhere in these Bylaws. The absence of such an agreement shall not assure the provider continued access to Hospital facilities, staff, or equipment after expiration of the contract, employment or arrangement; such access may be denied to any provider notwithstanding his or her privileges or previous authority, if such access is rendered unavailable by the Hospital's contracts with other providers or by other changes in Hospital operations.

B. **Leave of Absence:** Any provider may take leave of absence from the Medical Staff for military, health, professional, or other reasons for a period of not more than twelve (12) months by notifying the CEO and the President of Staff, in writing, of the date of commencement, expected duration, and reasons for the leave of absence. In addition, any provider who has not exercised his or her clinical privileges or practice authority at the Hospital for a continuous period of four (4) months and any provider suffering automatic sanctions due to sickness or disability may be involuntarily placed on

leave of absence by action of the Active Staff. During a period of leave of absence, no participation in Medical Staff activities shall be required and all clinical privileges and office-holding or voting rights shall be suspended. Return from leave of absence shall require written application, and shall require compliance with any requested health assessment, demonstration of current compliance with all qualifications for privileges, and other requirements which the CEO or Active Staff shall determine appropriate. Failure to apply for reinstatement within twenty-two (22) months from the date of commencement of leave shall be treated as a voluntary resignation of membership and voluntary relinquishment of all privileges or practice authority and will not entitle the provider to hearing and appeal or other procedures. However, denial of a timely and complete application for reinstatement to the Medical Staff will be treated as denial of an application for appointment to the Medical Staff and will to the same extent entitle the provider to hearing and an appeal, if applicable.

## VII. CLINICAL SERVICES

### A. Non-Departmentalized Medical Staff

The Medical Staff of Lucas County Health Center is not formally departmentalized. Accordingly, Medical Staff credentialing, privileging and corrective action are performed by the Medical Executive Committee for the entire medical staff, without departmental action; and Medical Staff functions such as quality improvement, utilization review, and so forth are performed hospital-wide by committees appointed by the Medical Executive Committee.

## VIII. COMMITTEES AND OFFICERS OF MEDICAL STAFF

### A. Committees

The chairpersons of all Medical Staff committees and the officers of the Medical Staff shall be elected or appointed in accordance with the provisions of the Medical Staff Bylaws prior to assuming their duties in those offices. Said individuals shall act on behalf of the Hospital when performing their duties under the Bylaws and shall perform such additional duties as may be assigned from time to time by the Board or by the CEO. All minutes, reports, recommendations, communications, and actions taken with respect to credentialing, peer review, quality assessment or related matters made or taken by the Board or its committees or Medical Staff departments, committees and/or officers assigned a review function on behalf of the Hospital are deemed to be covered by the provisions of Iowa Code Sections 22.7, 135.40-135.42, 147.135, or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

### B. Officers of the Staff

#### 1. Identification.

The officers of the staff shall be:

a. President
b. Vice President
c. Secretary-Treasurer

**2. Qualifications.**

Officers must be members of the Active Staff for one (1) year at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The Officers of the Medical Staff must be physicians who have demonstrated competence in his/her field of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities.

**3. Election.**

Officers shall be elected at the annual meeting of the Medical Staff. Only Active staff members shall be eligible to vote. Nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes.

**4. Term of Elected Office.**

Each officer shall serve a two (2)-year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected.

**5. Removal of Staff Officers.**

Except as otherwise provided, removal of an elected Medical Staff officer may be initiated by the Board acting upon its own recommendation and/or effected by a two-thirds (2/3) majority vote of the members of the Active Staff. Removal shall be for failure to meet the requirements of or to conduct those responsibilities assigned by these Bylaws.

## C. Vacancies in Elected Office

The Medical Executive Committee shall fill vacancies in offices, other than that of President. If there is a vacancy in the office of President, the Vice President shall serve out the remaining term. A vacancy in the office of Secretary-Treasurer shall be filled by a special election conducted as soon as possible after the vacancy occurs following the general mechanisms outlined in the nomination process of these bylaws.

## D. Duties of President

The President shall serve as the head of the Medical Staff and its principal elected official. This position must be a physician. As such, he/she shall:

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

2. Be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services within the Hospital and for the effectiveness of the patient care monitoring and evaluation process and other quality maintenance functions delegated to the Medical Staff.

3. Develop and implement, in cooperation with the department chairpersons, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, and retrospective patient care review.

4. Appoint the department chairperson and the Medical Staff representatives to Medical Staff and Hospital management committees with participation and consultation by the CEO.

5. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board, the CEO, and other appropriate officials of the staff.

6. Be responsible for the enforcement of Medical Staff Bylaws and Rules and Regulations, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a provider.

7. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

8. Serve as chair of the Medical Executive Committee and as an ex officio member of all other staff committees.

### E. Duties of Vice President

The Vice President shall be a member of the Medical Executive Committee and the Medical Staff Bylaws Committee. This position must be a physician. As such he/she shall:

1. In the absence of the President, the Vice President shall assume all duties and the authority of the President.

2. Perform such other duties as ordinarily pertain to his/her office.

3. Perform such additional duties as may be assigned to him/her by the President, Medical Executive Committee, or Board.

### F. Duties of Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee and the Medical Staff Bylaws Committee. This position must be a physician. As such, he/she shall:

1. Give proper notice of all Medical Staff meetings on order of the appropriate authority.

2. Approve accurate and complete minutes for all meetings.

3. Perform such other duties as ordinarily pertain to his/her office.

4. Perform such additional duties as may be assigned to him/her by the President, Medical Executive Committee, or Board.

### G. Additional Officers

The Board may, after considering the advice and recommendations of the Medical Staff, appoint additional providers to medico-administrative positions within the Hospital to perform such duties as

prescribed by the Medical Executive Committee and the Board, or as defined by amendment to these Bylaws. To the extent that any such officer performs any clinical function, he/she must become and remain a member of the Medical Staff. In all events, he/she must be subject to these Bylaws and to the other policies of the Hospital.

## H. Committees of the Medical Staff

### 1. General Provisions.

Committees of the Medical Staff shall be designated as standing or special. Standing committees shall be those committees created to fulfill functions delineated in these Bylaws. Special committees shall be those committees that the Medical Executive Committee shall appoint as necessary.

### 2. Term.

All standing committee appointments shall be for a period of two (2) years.

### 3. Committee Chairperson.

The Medical Staff President shall appoint the chairperson of each committee with final approval by the Board.

### 4. Authority.

a. All committees of the Medical Staff, except the Medical Executive Committee, are subject to the authority of and shall report to the Medical Executive Committee.

b. Unless otherwise provided in these Bylaws or directed in writing by the Medical Executive Committee, any committee may recommend any action to the Medical Executive Committee by the vote of a majority of its members, including Advanced Practice Providers, present at a meeting in which a quorum is present.

c. All committees shall prepare and file minutes of all meetings. A copy of these minutes shall be on file in the Medical Staff Office.

## I. Medical Executive Committee

### 1. Composition.

The Medical Executive Committee members shall be: the Medical Staff President who shall be its chairperson and shall preside at meetings; the CEO who shall be ex officio without vote and shall sit when the committee is in executive session; the Vice President, and the Secretary-Treasurer. The Chief Nursing Officer and Chief Operations Officer may attend at the invitation of the Medical Executive Committee but shall not attend when the Medical Executive Committee is in executive session.

### 2. Duties.

The duties of the Medical Executive Committee shall be to:

c. Coordinate the activities and clinical policies of the various departments;

d. Receive and act upon those committee reports as specified in these Bylaws and to make recommendations concerning them to the CEO and the Board;

e. Implement policies of the Hospital that will affect the Medical Staff;

f. Represent and act on behalf of the Medical Staff and provide liaison among the Medical Staff, the CEO, and the Board;

g. Keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital;

h. Enforce Hospital and Medical Staff Rules in the best interest of patient care and of the Hospital with regard to all persons who hold appointment to the Medical Staff;

i. Refer all questions of clinical competence, patient care and treatment, case management or inappropriate behavior of any Medical Staff appointee to the Board for appropriate action;

j. Be responsible to the Board for the implementation of the Hospital's quality improvement plan as it affects the Medical Staff; and

k. Review the Medical Staff Bylaws, policies, rules and regulations, and associated documents of the Medical Staff at least once a year and recommend such changes as may be necessary or desirable.

**3. Credentials Functions.**

The Medical Executive Committee shall act as the credentials committee, and in that capacity shall:

a. Review all applications for Medical Staff membership and clinical privileges and review applications for reappointment to the Medical Staff and renewal of privileges, and develop recommendations as to classification of staff and the extension of privileges, pursuant to the procedures set forth in these Bylaws; and

b. Promptly process all corrective action matters, conduct investigations thereon, and take appropriate action or make appropriate recommendations to the Board, pursuant to the procedures set forth in these Bylaws.

**4. Meetings, Reports, and Recommendations.**

The Medical Executive Committee shall meet at least once each month or more often if necessary to transact business. The Secretary-Treasurer will maintain reports of all meetings, and these reports shall include the minutes of the various committees and departments of the staff. Copies of all minutes and reports of the Medical Executive Committee shall be kept on file in the Medical Staff Office. Recommendations of the Medical Executive Committee shall be transmitted to the Board with a copy to the CEO. The Chairperson of the Medical Executive Committee shall be available to meet with the Board, or its applicable committee, on all recommendations that the Medical Executive Committee may make.

## J. Standing Committees

The Medical Executive Committee shall designate such other committees, from time to time, as it deems appropriate to carry out all necessary Medical Staff functions. One committee may be responsible for one specific function, or for several functions, as determined by the Medical Executive Committee. The committees may have appointed Medical Staff members or may function by meeting periodically with the Medical Staff. Each committee shall include Hospital department heads as appropriate, and the CEO may attend any committee meetings. Members of the Affiliate, Courtesy, or Consulting Staffs, Advanced Practice Practitioners, and employees or contractors of the Hospital may be appointed to any committee by the Medical Executive Committee. To the extent possible, appointments will be designed so that no Medical Staff member is required to regularly attend more than one or two committee meetings per month.

Any committee may also include one member of the Board by agreement between the Board Chairman and President of Medical Staff. Each committee shall maintain permanent written records of all actions taken, and report regularly to the Medical Executive Committee. One-half (1/2) of the members of a committee shall constitute a quorum.

The specific functions to be carried out shall include, in addition to other functions designated from time to time, the following:

### 1. Medical Records.

Examine medical records and be responsible for their maintenance at the required standards. Currently maintained records shall be reviewed to assure that they properly describe the condition and progress of the patient, therapy provided, outcomes, and compliance with transfer criteria.

### 2. Utilization Review.

Conduct utilization review in accordance with the Hospital's Utilization Review Plan. The committee shall review and evaluate the plan, and recommend any indicated revisions, at least annually. No provider shall have utilization review responsibilities in connection with any case in which he or she was professionally involved. The committee shall review and evaluate average lengths of stay to ensure compliance with Critical Access Hospital standards or other applicable standards.

### 3. Pharmacy and Therapeutics.

Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. Assist in the formulation of professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs maintained and/or administered in the Hospital.

### 4. Infection Control.

Be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities.

5. **Trauma Committee / Emergency Room.**

Formulate and implement policies and procedures for the emergency departments, and provide leadership in the trauma program of the Hospital. Review all trauma cases with the trauma team at least quarterly.

6. **Blood Usage.**

Review all blood transfusions for proper utilization, with particular attention to the use of whole blood versus component blood elements.

7. **Quality and Risk Management.**

Conduct quality and risk management activities in accordance with the Hospital's Quality Management Plan and exercise such responsibility and authority as are provided therein. The committee performs and reviews all internal and external peer review records.

### K. Other Committees

1. **Creation, Elimination or Combination of Committees.**

The Medical Executive Committee may create, eliminate, or combine committees when it deems such actions to be in the best interests of the Hospital and Medical Staff.

## IX. MEETINGS

### A. General Staff Meetings

1. **Regular Meetings.**

a. An annual Medical Staff meeting shall be held each calendar year, near the end of the term, and preceding the June Board meeting.

b. Order of Business and Agenda

The President shall determine the order of business at regular meetings. The agenda may include, but is not limited to, the following:

i. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.

ii. Administrative reports from the CEO, the President of the Staff, departments, and committees.

iii. The election of officers and of representatives to staff and Hospital committees, when required by these Bylaws.

iv. Reports by responsible officers, committees, and departments on the overall results of patient care audits and other quality maintenance activities of the Medical Staff and on the fulfillment of the other required Medical Staff functions.

v. Recommendations for improving patient care within the Hospital.

vi. New business.

**2. Special Meetings.**

Special meetings of the Medical Staff may be called at any time by the Board, the Medical Staff President, or the Medical Executive Committee and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

**B. Committee Meetings**

**1. Regular Meetings.**

Committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be at least annually.

**2. Special Meetings.**

A special meeting of any committee and department may be called by, or at the request of, the chairperson, the Board, the Medical Staff President, or by one-third of the group's current members. No business shall be transacted at any special meeting except that the stated in the meeting notice.

**C. Notice of Meetings, Quorum, Voting, Minutes, Procedural Requirements**

**1. Notice of Meetings.**

Written notice stating the place, day and hour of any general staff meeting, of any special meeting, or of any regular committee or department meeting not held pursuant to resolution shall be delivered either personally, by U.S. mail, postage prepaid, or by electronic mail to each person entitled to be present not less than five (5) working days nor more than thirty (30) calendar days before the date of such meeting. Notice of department or committee meetings 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 the address as it appears in the records of the Hospital. If e-mailed, the notice of the meeting shall be deemed delivered upon receipt by the sender of verification of delivery. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

2. **Quorum**.

a. General Staff Meetings

The presence of fifty percent (50%) of the voting members of the active Medical Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment to these Medical Staff Bylaws and transaction of all other business.

b. Medical Executive Committee and Department Meetings

The presence of thirty-three percent (33%) of the voting members of a department shall constitute a quorum at any meeting of such department. The presence of fifty percent (50%) of the Medical Executive Committee and other standing committees shall constitute a quorum.

**3. Manner of Action.**

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a department or committee by a notice in writing setting forth the action so taken and signed by each member entitled to vote.

**4. Minutes.**

Minutes of all meetings shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the Medical Executive Committee, and made available to the Medical Staff. A permanent file of the minutes of each meeting shall be maintained.

## D. Attendance Requirements

**1. Regular Attendance.**

Each member of the Medical Staff category required to attend meetings shall be required to attend:

a. The Medical Staff annual meeting.

b. At least fifty percent (50%) of all other Medical Staff meetings duly convened pursuant to these Bylaws. Attendance at regular Medical Staff meetings, other than the annual meeting, can be attained by either personal attendance or phone/video conference.

c. At least fifty percent (50%) of all meetings of each department and committee of which he/she is a member.

**2. Absences.**

a. Any member who is compelled to be absent from a Medical Staff, department, or committee meeting shall promptly provide the reason for such absence. Unless excused for good cause, failure to meet the attendance requirements may be grounds for investigation.

b. Reinstatement of a Medical staff member whose membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment. The number and percentage of excused absences shall be taken into consideration for the individual provider at the time of reappointment.

**3. Special Appearance.**

A provider whose patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting shall be so notified. The chairperson of the meeting shall give the provider at least fourteen (14) days advance written notice of the time and place of the meeting. Failure of a provider to appear at any meeting with respect to which he/she was given such special

notice may, unless excused by the Medical Executive Committee upon a showing of good cause, result in a summary suspension of all or such portion of the provider's clinical privileges as the Medical Executive Committee may direct. (See Section XIII.C.)

## X. DIRECT ACTION BY BOARD OF TRUSTEES

### A. Assumption of Duties by Board

Whenever the Board determines, in its sole discretion, that the Medical Executive Committee is unable or unwilling to effectively perform any of its responsibilities under these Bylaws; or whenever it is determined by the Chairperson of the Board and the President of the Medical Staff that a matter should be handled directly by the Board; then the Board itself may, as to the matter at hand, assume and carry out some or all of the responsibilities which would otherwise be handled by the Medical Executive Committee under these Bylaws. In such case, and to the extent it deems appropriate, the Board may appoint any individuals it deems to be suitable to assume and carry out the specific powers and responsibilities which would otherwise be assigned to the CEO, Medical Staff President, and/or Medical Executive Committee, under the provisions of these Bylaws. The persons so appointed shall, while acting in such capacity, have all of the authority, privileges, immunities, and other protections which are afforded by these Bylaws, subject to any limitations or conditions imposed by the Board.

### B. Compliance with Bylaw Requirements

Upon assumption of duties or appointment of individuals as provided in Section A above, the procedures set forth in these Bylaws shall be followed to the extent reasonably possible under the circumstances; but it shall be sufficient that the Board, the CEO, and the other persons involved by appointment of the Board, and any member of the Medical Staff or other person participating or cooperating with such persons during the proceedings, attempt in good faith to comply with such procedures to the extent reasonable and practicable under the circumstances and limitations of the case.

## XI. INCAPACITY/IMPAIRMENT AND PROFESSIONAL BEHAVIOR

If a provider fails to conduct themselves appropriately, the matter shall be addressed in accordance with the Medical Staff Rules and Regulations pertaining to Impaired Practitioners, Harassment, Disruptive Practitioners, the corrective action provisions of the Medical Staff Bylaws or Hospital Policy and Procedure "Disruptive Practitioner," whichever is appropriate

## XII. INVESTIGATIONS, CORRECTIVE ACTION, AND SUSPENSION

### A. Informal Resolution

All providers are encouraged to resolve problems on an informal and professional basis whenever possible. When this is not possible, or when it is believed that the Medical Executive Committee could assist in resolving the problem, the issue may be referred to the Medical Executive Committee for action.

## B. Corrective Action

### 1. Initiation.

Whenever the activities or professional conduct, including any oral or written act, either within or outside of the Hospital, of any staff member with clinical privileges are, or are reasonably likely to be, contrary to patient safety or the delivery of quality patient care, or are reasonably likely to be disruptive to Hospital operations or the continued effective operation of the Hospital, corrective action against that staff appointee may be initiated by any officer of the Medical Staff, by the chair of any department or committee of the Medical Staff, by the CEO, any member of the Medical Executive Committee, or by the Board.

### 2. Requests and Notification.

All requests for investigation shall be signed and submitted in writing to the Medical Staff President or, as an alternate, the CEO and shall include a description of the conduct or statement that constitutes the grounds for the request. Upon receipt of such request, the Medical Staff President or, as an alternate, the CEO shall inform the Medical Executive Committee, which shall then appoint an Ad Hoc Committee to investigate the matter.

### 3. Investigation.

Any alleged conduct for which an investigation has been requested shall initially be considered by the Ad Hoc Committee. After conducting a preliminary investigation, the Ad Hoc Committee may, at their sole discretion, request a provider to appear before the Committee. This appearance shall not constitute a hearing and shall be preliminary in nature. None of the procedural rules provided in these Bylaws or the Fair Hearing Plan with respect to hearings or appeals shall apply. The Ad Hoc Committee shall make a record of all such appearances.

### 4. Findings and Recommendations of the Ad Hoc Committee.

At the conclusion of the Ad Hoc Committee's investigation, it shall deliver a report to the Medical Executive Committee that shall include findings and recommendations. Any action by the Medical Executive Committee to reduce, suspend, or revoke clinical privileges or to suspend or to revoke Medical Staff appointment shall confer upon the Medical Staff member the procedural rights set forth in the appropriate section of the Fair Hearing and Appeal Procedures (see Section XV).

## C. Summary Suspension

Whenever a Medical Staff appointee's activities or professional conduct, including any oral or written act, either within or outside of the Hospital, are, or are reasonably likely to be contrary to patient safety or the delivery of quality patient care, disruptive to Hospital operations or the continued effective operation of the Hospital, the Medical Staff President, the CEO, or the chairperson of the Board shall have the authority to summarily suspend the Medical Staff appointment status or all or any portion of clinical privileges of such staff appointee. Any summary suspension imposed shall be effective immediately upon imposition and shall, in the event corrective action is recommended, continue pending resolution of the request for corrective action, except as otherwise determined by the CEO. The Medical Staff President, the CEO, or the chairperson of the Board shall promptly notify the provider by Special Notice of the suspension. If the suspension or restriction remains in effect for fifteen (15) days or more, the affected provider is entitled to special hearing procedures outlined in the Fair Hearing and Appeal Procedures (see Section XV).

### D. Automatic Suspension

1. A staff appointee whose license to practice in Iowa is revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital as long as the revocation or suspension shall remain in effect. A staff appointee who has been placed on probation by the Iowa Board of Medicine may be automatically suspended or his/her privileges may be retained subject to such conditions as are imposed by the Medical Executive Committee or the Board of Trustees.

2. A staff appointee whose state or federal (D.E.A.) narcotics registration is revoked or suspended shall, at a minimum, immediately and automatically be divested of his/her right to prescribe medications covered by such registration. As soon as possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the state or federal registration was revoked or suspended. The Executive Committee may the take such further corrective action as is appropriate to the facts disclosed in its investigation.

3. A staff appointee who is excluded as a provider from any governmental health care program such as Medicare or Medicaid or who was convicted of any felony or any crime arising out of professional practice, shall immediately and automatically be suspended from practicing in the Hospital.

4. A staff appointee who fails to complete medical records as required by these Bylaws, Rules and Regulations, and Hospital Policies and Procedures, or fails to meet the basic qualifications for membership of the Medical Staff shall be automatically suspended from exercising his/her clinical privileges in accordance with the procedures set forth in the rules and of the Medical Staff.

In the event of an automatic suspension pursuant to subsections "1." or "2." of this section, the affected provider shall be entitled to the hearing procedures found in the Fair Hearing and Appeal Procedures (see Section XV). In the event of an automatic suspension pursuant to subsection "4." of this section, the provider is entitled only to submit a written statement as outlined in the Fair Hearing and Appeal Procedures (see Section XV).

### E. Care of Suspended Provider's Patients

Immediately upon imposition of a summary suspension, the appropriate department chairperson, or in his/her absence the Medical Staff President, shall assign to another individual with appropriate clinical privileges the responsibility for care of the individual's patients in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of a substitute. It shall be the duty of the Medical Staff President and the department chairperson to cooperate with the CEO in enforcing all suspensions.

## XIII. PEER REVIEW/PRIVILEGE AND IMMUNITY

### A. Conditions

By applying for appointment and clinical privileges, the provider accepts the following conditions regardless of whether or not he/she is granted appointment or privileges, and intends to be legally bound thereby. These conditions shall remain in effect for the duration of any term of appointment that may be granted.

## B. Interpretation

It is the intention of these Bylaws to define the term "peer review" broadly, and to secure to those who engage in any aspect of peer review in, at, for or on behalf of the Hospital and its Medical Staff, the broadest possible privilege and immunity from liability. This Article XIV and these Bylaws will be interpreted to effectuate this objective. The privileges and immunities set forth in this Article XIV or elsewhere in these Bylaws shall be cumulative of other protections provided by law.

## C. Authorization and Release

The following shall be express conditions on the application for, or the holding or exercise of, membership and privileges at the Hospital. Each applicant and each member hereby expressly:

1. Authorize this Hospital, its Trustees, officers, employees and agents, and this Medical Staff, its officers, members and committees, to request, receive, furnish, discuss, consider and act upon all relevant information bearing upon such provider's qualifications or performance;

2. Release from liability, to the fullest extent permitted by law, this Hospital and its Trustees, officers, employees and agents, and this Medical Staff, its officers, members and committees, and others who furnish information to them or cooperate with them, for requesting, receiving, considering discussing, furnishing or acting upon information as authorized above in connection with the peer review functions of this Hospital and its Medical Staff or of other hospitals and their medical staffs;

3. Authorize and direct any other hospital, institution, organization or individual to furnish information upon request, and release from liability any such hospital, institution, organization or individual for furnishing such information, when reasonably believed to relate to the peer review responsibilities of this Hospital and its Medical Staff;

4. Agree to furnish upon request all information in his/her possession which may be relevant to peer review of himself or another applicant or member of the Medical Staff, and to fulfill assigned responsibilities under these Bylaws in the peer review functions of the Hospital and its Medical Staff; and

5. Pledge to maintain the confidentiality of the minutes, records and work product of the Hospital and its Medical Staff related to peer review. This provision will not be construed to prohibit mandatory disclosures under state or federal law, or disclosures required under these Bylaws, or disclosures to the government or professional associations made in the context of peer review.

## D. Scope of Peer Review

Each officer and committee of the Medical Staff is hereby constituted a peer review body and assigned peer review responsibility within the Hospital. All officers and committees and their agents (including the CEO and his/her designees) are authorized to engage in peer review activity and to investigate and make recommendations to the Medical Executive Committee concerning applicants or members of the Medical Staff on all matters coming to their attention and within their areas of primary or delegated responsibility, reflecting on credentials, performance, quality of practice or quality of patient care, or suggesting violation of these Bylaws. Each other provider or officer or employee of the Hospital, and each other committee of the Medical Staff, shall furnish such investigating body or committee with any requested information which is in their possession and which may bear on the matter under investigation.

### E. Information Privileged

All statements, disclosures, reports, recommendations and other communications made in connection with peer review activities of the Hospital shall, to the fullest extent permitted by law, be confidential and privileged from further disclosure, except as otherwise provided in these Bylaws.

## XIV. FAIR HEARING AND APPEAL PROCEDURES

### A. Statement of Policy

The purpose of the provisions outlined is to set forth procedures and guidelines to govern the Medical Staff and the Board in their consideration and treatment of disputes regarding applications, reappointments, and corrective action, meeting the following criteria;

1. The procedures and guidelines provide fairness to any provider whose staff membership and/or privileges are in dispute, either in the application, reappointment, or corrective action proceedings, by providing the provider fair notice and an opportunity to be heard, and fair consideration of the facts so that only legitimate criteria relating to the quality of treatment and patient care, professional behavior, the mission and goals of the Hospital, and the performance of necessary staff functions will be applied and utilized; and

2. The procedures and guidelines are workable and realistic when considered in light of the size and resources of the Medical Staff, the Hospital, and the Board.

### B. Right to Hearing

Except as expressly limited by these Bylaws, a provider shall have the right to request a hearing whenever the Medical Executive Committee makes a recommendation or the Board takes action which, if adopted as final action, would result in:

1. Denial of Medical Staff membership or clinical privileges, on initial application or on application for reappointment or renewal. Excluded from this provision are denials for reasons of incomplete application, material inaccuracy in the application or any reason unrelated to competence or professional conduct of the applicant.

2. Denial of requested increase in clinical privileges.

3. Involuntary suspension or expulsion from the Medical Staff.

4. Involuntary limitation, reduction, suspension, or termination of clinical privileges.

5. Involuntary imposition of extraordinary observation, review, or reporting requirements, other than for the purpose of evaluating credentials or performance.

### C. Request for Hearing

#### 1. Notice of Decision

In all cases in which the Medical Executive Committee or the Board has taken action or made a recommendation constituting grounds for a hearing, a written copy of the recommendation or written description of the action taken, together with a statement of the grounds on which such

recommendation or action is based, shall be furnished to the CEO. The CEO shall promptly notify the affected provider in writing of the action taken and furnish a copy of the recommendation or action taken and the grounds. The CEO shall furnish the provider with a summary of his/her hearing and appeal rights under the Bylaws and advise the affected provider of his/her right to request a hearing under these Bylaws.

### 2. Request for Hearing

The affected provider shall have thirty (30) days following the date of receipt of such notice within which to request a hearing before the Hearing Committee. The request for hearing must be by written notice to the CEO. In addition to requesting a hearing, such notice must respond, point by point, to each finding or ground relied upon by the Medical Executive Committee in support of its action or recommendation, and indicate in what respect, from the affected provider's point of view, each finding or ground, and the final action or recommendation itself, is in error. In the event the provider does not request a hearing within the time and in the manner prescribed, or in the event the notice is incomplete, and the provider does not furnish a complete notice within seven (7) days after the CEO notifies the provider of the deficiencies, he/she shall be deemed to have accepted the action involved, and waived the right to hearing and appellate review. Said action shall thereupon become effective immediately or as otherwise provided in these Bylaws.

## D. Hearing Committee

### 1. Composition

Within ten (10) days after receipt of a request for hearing, or as soon thereafter as reasonably possible, the CEO, after consultation with the President of the Medical Staff, shall appoint a Hearing Committee and provide each member of the Hearing Committee with copies of the action or recommendation, the notice to the affected provider, and the provider's request for hearing. The committee shall be formed under the following guidelines:

a. The committee will be composed of not fewer than three (3) providers, a majority of whom must be physicians, and none of whom should be in direct economic competition with the affected provider as that term is defined by the Hospital. The committee should, to the extent possible, be comprised of providers with privileges at the Hospital, but this guideline shall not control when its application would result in insufficient committee members or would require appointment to the committee of a provider who is in direct economic competition with the affected provider or has some other conflict of interest. The affected provider may object to any designated hearing officer on the basis of economic competition or bias within seven (7) days of being notified of the composition of the hearing committee. Upon receipt of said objection, the CEO will evaluate the objection and take appropriate action.

b. By mutual written agreement between the provider requesting the hearing and the CEO, the composition of the committee may be varied from the requirements of the preceding paragraph in any manner, but the provider requesting the hearing shall be deemed to have consented to any time delay attributable to such variance.

c. When the provider requesting the hearing is a non-physician provider, reasonable efforts will be made for at least one (1) member of the Hearing Committee to be a non-physician, preferably but not necessarily of the same profession as the individual requesting a hearing. A provider who is not affiliated with the Hospital may be appointed to fill this position, if necessary.

d. No person shall be disqualified from serving on the Hearing Committee because of prior knowledge regarding the facts of the case.

e. One of the members of the Hearing Committee shall, at the time of appointment, be designated Presiding Officer of the Committee by the CEO and shall be provided with a list of witnesses who are at that time expected to testify at the hearing in support of the action or recommendation.

If the hearing is based on action by the Board, this subsection 1. shall be modified by Section G, below.

**2. Hearing Judge**

The CEO may, after consultation with the President of the Medical Staff, appoint a Hearing Judge as fact finder in lieu of the Hearing Committee described in this Section XV. When so appointed, the Hearing Judge shall have the same authority and responsibilities as a Hearing Committee and shall follow, insofar as practical, the same procedures. Such a Hearing Judge is to be distinguished from the Hearing Officer appointed under subsection D.1 of this Section to assist a Hearing Committee.

**3. Authority of Hearing Committee**

The Hearing Committee (through its Hearing Officer) shall have authority to:

a. Establish the time, place, manner, and procedure for conducting the hearing, consistent with these Bylaws;

b. Hold a preliminary meeting with the parties for the purpose of clarifying issues, establishing procedures, or otherwise aiding the Hearing Committee;

c. Rule on the admissibility of the evidence, and determine the weight to be accorded to evidence which is admitted;

d. Request (subject to Section D.1.(a) and (b)) other members of the Medical Staff, other clinical providers with privileges at the Hospital, or outside experts to examine questions within their respective specialties or knowledge where a dispute exists between the position of the affected provider and the position of the Medical Executive Committee, and report to the Hearing Committee their opinions and the basis for those opinions;

e. Conduct a hearing, consider and receive evidence, and deliberate and reach a determination in the form of a final recommendation;

f. Direct the attendance and participation of witnesses, and the submission and introduction of documentary evidence, whether or not offered by the Medical Executive Committee or the affected provider; and

g. Take such other actions as will facilitate its business.

### 4. Decision of Committee

The decision of the Hearing Committee shall be the final decision or recommendation submitted to the Board. Upon reaching a decision, the Hearing Committee must reduce it to writing setting forth the recommendation or action and the grounds on which it is based. Only Hearing Committee members who have attended all parts of the hearing shall be entitled to participate in the deliberations or vote of the Hearing Committee. A quorum consists of not less than one-half (not to be fewer than two (2)) Hearing Committee members. There shall be no voting by proxy.

## E. Pre-hearing Procedures

### 1. Notice of Hearing

The Hearing Committee shall schedule the hearing. The Medical Executive Committee and the affected provider shall be given written notice stating the place, time and date of the hearing not less than thirty (30) days prior to the scheduled date thereof, together with a written list of the witnesses expected to be called to testify in support of the recommendation or action at the time of the hearing. The notice shall include a statement of the alleged acts or omissions of the affected provider, a list by number of the specific or representative patient charts in question and/or other reasons or subject mater forming the basis for the adverse recommendation or action which is the subject of the hearing.

### 2. Response and List of Witnesses of Affected Provider

Within fourteen (14) days after receipt of the notice of hearing, the affected provider shall furnish to the CEO, his/her written response to the statement of reasons and a list of witnesses (and their addresses) who may or will be called as witnesses in support of the affected provider's position at the time of the hearing.

### 3. Pre-hearing Conference

Not less than seven (7) days prior to the scheduled commencement of the hearing, the Hearing Committee or its Hearing Officer shall meet with the parties for the purpose of conducting a pre-hearing conference to discuss possible stipulations of fact, amendments to the grounds for action or the issues in dispute, and changes in the witness or evidence list of each party. Any further procedures established by the Hearing Committee for the conduct of the hearing should be explained at such time. The Hearing Committee and the parties shall endeavor to agree on evidence and the procedures and narrow the issues as much as possible, so that both sides will receive fair consideration at the hearing and procedural issues can be kept to a minimum. Although each side shall be allowed some latitude in presenting evidence at the hearing, responding to developments in the case, and otherwise fully defending its position, the Hearing Committee shall have the absolute authority and discretion in the conduct of the hearing to preclude either side from presenting any issues, arguments, witnesses, or evidence at the hearing which, without good reason, were not identified in the outline of the case, at the preliminary meeting or at the earliest possible time thereafter, or which are otherwise inconsistent with the statements, disclosures, agreements, and decisions made in the outline of the case or at the preliminary meeting. Failure of either party to appear at and participate in the preliminary meeting shall be deemed to be acceptance of all agreements and decisions made at or as a result of the preliminary meeting.

At any time during the proceedings, the Hearing Judge may require the affected provider and the Medical Executive Committee to each submit an outline for the pre-hearing conference for

transmittal to the Hearing Committee and to the other party, setting forth, so far as is then reasonably known:

a. The issues which each party proposes to raise at the hearing.

b. Changes in the witnesses whom each party proposes to call at the hearing and the subject or subjects on which each witness is expected to testify.

c. A description of written or documentary evidence which each party anticipates introducing as evidence at the hearing.

d. A short summary of what the party expects to demonstrate at the hearing in support of its position.

e. The specific result or results requested at the Hearing Committee.

## F. Conduct of Hearing

### 1. Principles

The hearing shall be conducted according to the following principles:

**a. Cross-examination and Rebuttal.** No testimony shall be offered or submitted to the Hearing Committee by the other party or by individuals called upon for information by the Hearing Committee itself, without both the affected provider and the Medical Executive Committee having the opportunity to be present, to question the witness, to respond, and to rebut the evidence.

**b. Evidence.** No evidence, testimony, or documentation shall be considered by the Hearing Committee which has not been received as evidence at a meeting at which both sides have been present. The decision of the Hearing Committee shall be based upon the evidence.

**c. Representation.** The Medical Executive Committee or the Board, whichever body rendered the decision from which the provider has requested the hearing, shall name a spokesman to represent it at the hearing. Each party shall be entitled to be accompanied by and represented at the hearing by an attorney or other representative.

**d. Chairperson's Role.** The Hearing Judge (or the Hearing Officer if one is appointed), shall conduct the hearing. The Hearing Judge shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, and shall generally maintain decorum. The Hearing Judge shall determine the order of procedure during the hearing, and shall have the authority, in his or her discretion and in accordance with these Bylaws, to make all rulings on questions, which relate to matters of procedure and to admissibility of evidence. If a person other than the Hearing Officer of the Hearing Committee acts as Hearing Judge, he or she may upon request of the Hearing Committee participate in its deliberations as a consultant, but shall not be entitled to vote on the decision of the Committee.

The chairperson and all other members of the Hearing Committee who have attended all parts of the hearing shall vote.

e. **Rules of Evidence.** The hearing will not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs. Each party shall have the right to submit memoranda concerning any issue of procedure or fact, and such memoranda shall become a part of the hearing record.

The Hearing Judge may also be an attorney or other person knowledgeable of general rules of hearing procedure, who shall not be a participant in the hearing in any other capacity. If appointed, such Hearing Judge shall carry out all of the procedural duties set forth herein. The hearing committee may obtain its own legal counsel regardless of whether that counsel acts as the Hearing Judge. The Hospital may pay any fees and expenses of legal counsel to the Hearing Committee and such payment shall not be deemed to render such person biased, partial, or unqualified.

f. **Rights of Both Sides.** At the hearing, both sides shall have the right to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, and to rebut any evidence. If the provider requesting the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

g. **Burden of Proof.** At any hearing resulting from an action or recommendation during corrective action proceedings, the spokesman for the Board or the Medical Executive Committee shall have the initial burden of producing evidence in support of the action or recommendation. At any hearing resulting from an action or recommendation during the original application or reappointment processes, and at any hearing following corrective action proceedings once the spokesman has produced the evidence in support of the action or recommendation, the individual requesting the hearing shall have the ultimate burden of proving by convincing evidence that (a) the grounds for the action are not supported by the evidence, or (b) conclusions drawn there from are arbitrary and capricious.

h. **Hearing Committee Members.** Members of the Hearing Committee are authorized to take a participatory role in the proceedings, to question witnesses, to call upon witnesses for information within their possession, to direct the submission of additional evidence and documentation, to question the Medical Executive Committee and the affected provider, and to see that the record contains all information which the Hearing Committee considers necessary in order to reach a decision.

**2. Attendance**

Failure without good cause of the affected provider who requested the hearing to appear and proceed at the hearing shall be deemed to constitute voluntary acceptance of the action or recommendation of the Medical Executive Committee and waiver of any appeal rights. Failure without good cause of the Board or Medical Executive Committee or its designee to appear and proceed at such a hearing shall be deemed to constitute a withdrawal of the recommendation or action involved.

**3. Record**

The Hearing Committee shall maintain a record of the hearing by a professional court reporter, the cost of whose fees shall be shared equally by the Hospital and the affected provider. The Hearing Committee may order that oral evidence be taken only on oath or affirmation administered by an

individual who is entitled to administer such oaths in this state. The provider is entitled to a copy of the record upon payment of any reasonable charges associated with the preparation thereof.

**4. Postponement and Extensions**

In addition to any postponements resulting from change in composition of the Hearing Committee by agreement, postponements and extensions of the time for the hearing may be requested by any person. Such requests may be granted by the Hearing Judge at any time for good cause shown by any person, and reasonable requests by the affected provider shall be granted whenever he or she represents in writing that additional time is needed to adequately prepare for the hearing.

**5. Recess and Deliberations**

The Hearing Committee may recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of the oral and written evidence, memoranda, and proposed findings, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations in private session and outside the presence of the individual who requested the hearing. At any time prior to rendering its decisions, the Hearing Committee may in its discretion, upon fair notice to each party, reconvene the hearing and hear additional evidence or argument.

**6. Written Statement**

Both parties may submit written statements at the conclusion of the hearing, within time limits established by the Hearing Committee. Such statements shall not constitute evidence.

**7. Decision**

A copy of the written decision of the Hearing Committee setting forth the grounds on which it is based shall be transmitted to the CEO, who shall promptly furnish a copy to the Board, the affected provider, and the Medical Executive Committee. The decision of the Hearing Committee constitutes the final recommendation to the Board. Either the affected provider or the Medical Executive Committee may appeal the decision of the Hearing Committee to the Board.

**G. Hearing Based on Action by Board of Trustees**

When the hearing is based upon action by the Board, the hearing shall be conducted by a Hearing Committee appointed by the Chairperson of the Board and consisting of not fewer than three (3) individuals. At least one (1) member of the Hearing Committee shall be a physician and, if the provider is a dentist or other non-physician provider, a reasonable effort should be made to place a dentist or other non-physician provider, preferably with the same specialty as the affected provider, on the Hearing Committee. One or more members of the Hearing Committee may be non-providers. The procedure established for hearing based upon final action and recommendation of the Medical Executive Committee shall otherwise be applicable, so far as possible, to hearings based upon action by the Board.

**H. Time Limits**

Reasonable effort should be made to conduct the hearing within ninety (90) days following the action or recommendation of the Medical Executive Committee or the action of the Board which prompted

the hearing. However, when the request for hearing is received with respect to a provider then under summary suspension or limitation, the hearing should be convened as soon as the arrangements may reasonably be made, preferably no later than thirty (30) days following the request for hearing, and all stated time limits may be shortened or extended by the Hearing Committee for good cause. The decision of the Hearing Committee shall be rendered in writing within ten (10) business days following the close of the hearing and submission of all post-hearing statements, and shall be furnished through the CEO to the affected provider, the Medical Executive Committee and the Board.

## I. Appellate Review

### 1. Appeal Procedure

Within ten (10) days after receipt of the decision of the Hearing Committee, the affected provider or the Medical Executive Committee, or any Board member (where the hearing has been held before a Hearing Committee appointed by the Board) may request an appellate review before the Board. The request must be delivered in writing to the CEO, and must also include a brief statement of the reasons for appeal. The CEO will then forward the request to the Board and to the other party to appeal.

If appellate review is not requested in such a period of time, the parties shall be deemed to have accepted the action involved, and it shall thereupon become final and shall be effective immediately, subject to final approval by the Board,

### 2. Time, Place, and Notice

The CEO shall deliver the request for appeal to the Chairperson of the Board. The Board shall promptly notify the parties of the time, place and date for appellate review. The appellate review should ordinarily not be more than thirty (30) days from the date of the request, although this time period may be altered by the Board for good cause.

### 3. Nature of Appellate Review

The proceedings by the Board are in the nature of an appellate review based upon the record of hearing before the Hearing Committee, provided that the Board may, in its sole discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the hearing. Each party has the right to present a written statement in support of its position on appeal. In its sole discretion, the Board may allow each party or representative to personally appear and present an oral argument. All meetings and proceedings of the Board in connection with appellate review shall be conducted in closed session to the extent permitted by law. At the conclusion of the proceedings, the Board may conduct deliberations outside the presence of the parties to the extent permitted by law. The Board may affirm modify or reverse the decision of the Hearing Committee or may refer the matter to the Hearing Committee for further review and recommendation.

### 4. Final Decision

Within thirty (30) days after conclusion of the proceedings before the Board, the Board shall render a final decision in writing setting forth the grounds on which it is based and deliver copies thereof to the CEO for transmittal to the parties and to the President of the Medical Staff. The decision of the Board is final and is effective immediately.

### 5. Right to One Hearing and One Appellate Review Only

No applicant, member, or provider is entitled as a matter of right to more than one (1) hearing on any single matter which may be the subject of a hearing, without regard to whether such subject is the result of action by the Medical Executive Committee or Board or a combination of acts of such bodies, or more than the one (1) appellate review before the Board on any single matter which may be the subject of an appeal.

### J. When Formal Hearing Procedures Do Not Apply

When the formal hearing procedures delineated in this Article do not apply to a recommendation or action, any Initial Applicant or Medical Staff appointee who believes he/she is aggrieved by any such action or recommendation of the Medical Executive Committee or Board may seek review of the action or recommendation by submitting a written statement taking exception to such action or recommendation and specifying the reason therefore. The statement shall be read or furnished to whichever body made the recommendation or took the action and made a part of the Staff Member's or Initial Applicant's permanent file. The statement may also request an opportunity to appear before the Medical Executive Committee or Board. After reviewing the Board may also, in its sole discretion, direct a hearing be held (even though one is not required), to review and make recommendations concerning the underlying matter at issue.

## XV. ADOPTION AND AMENDMENT OF BYLAWS

### A. Medical Staff Responsibility and Authority

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in a reasonable, timely, and responsible manner which reflects the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

### B. Methodology

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

1. Medical Staff

   The affirmative vote of a majority of the staff appointees eligible to vote on this matter, by action at a meeting in which a quorum is present, provided at least ten (10) days written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action; and

2. Board

   The affirmative vote of a majority of the Board, provided however, that in the event that the Medical Staff shall fail to exercise its responsibility and authority as required in these Bylaws, and after notice from the Board to such effect including a reasonable period of time for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws. Such action will only be taken in circumstances where immediate action is necessary to comply with any federal, state, or local law or to enable the Hospital to avoid potential liability. In such event, Medical Staff recommendations and views shall be taken into account by the Board during its

deliberations and in its actions pursuant to this paragraph. Any amendments so made should become effective when notice is given to the Medical Staff.

### C. Related Protocols and Manuals

The Medical Executive Committee will recommend to the Board, a set of Medical Staff Rules and Regulations, Credentialing Policies, and any other policy and procedure manual that further defines the general policies contained in these Bylaws. Upon adoption by the Board, these manuals will be incorporated by reference and become part of these Medical Staff Bylaws.

ADOPTED by the Active Medical Staff on July 3, 2019.

President of Medical Staff

APPROVED by the Board of Trustees on July 30, 2019

President of the Board of Trustees