Medical Staff Bylaws

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MEDICAL STAFF BYLAWS
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MEDICAL STAFF BYLAWS

DEFINITIONS

The following definitions shall apply to terms used in this policy:

1. "Board" or "Board of Directors" shall mean the governing body of Saint Francis Healthcare, which has ultimate authority and responsibility for establishing policy, maintaining quality care, and providing for organizational management and planning. For purposes of these Bylaws, except as context otherwise requires, the Board shall be deemed to act through the authorized actions of the officers of the Corporation and through the Chief Executive Officer of the Hospital.

2. "Chief Executive Officer" shall mean the individual appointed by the Board to act on the Hospital's behalf in the overall management of the Hospital.

3. "Clinical Privileges" shall mean the scope of diagnostic, therapeutic, medical, dental, podiatric or surgical services that a practitioner is authorized to provide to patients at the Hospital, based upon such factors as licensure, education, training, experience, competence, health status, insurance and professional judgment.

4. "Allied Health Professionals" shall mean an individual, not a member of the Medical Staff, who is trained in some aspect of the evaluation or treatment of human illness and who is allowed, after approval by appropriate bodies, to provide specific services to patients at the Hospital under the responsibility and supervision of a Medical Staff member.

5. "Emergency" shall mean a condition in which the life or bodily function of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6. "Hospital" shall mean Saint Francis Healthcare of Wilmington, Delaware.

7. "MEC" shall mean the Medical Executive Committee of the Medical Staff.

8. "Patient" shall mean any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

9. "Patient Encounter" shall mean an inpatient admission, inpatient consultation, surgical procedure, ambulatory surgery, gastrointestinal laboratory procedure, or emergency room consultation.

ARTICLE I
NAME AND PURPOSE

The physicians, dentists, podiatrists and psychologists who practice at Saint Francis Healthcare hereby establish an organization to be known as the Medical Staff of Saint Francis Healthcare.

ARTICLE II
MEDICAL STAFF MEMBERSHIP

2.1 MEDICAL STAFF MEMBERSHIP

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

Membership on the Staff shall confer on the Member only such clinical privileges and prerogatives as have been granted by the Board. No practitioner may admit or provide services to patients in the Hospital unless he or she is a Member of the Staff, has been granted temporary privileges, or is otherwise authorized to provide services pursuant to these Bylaws or the Credentialing Policy.

2.2 QUALIFICATIONS FOR MEMBERSHIP

The specific qualifications for Medical Staff membership shall be set forth in the Credentialing Policy.

2.3 CONDITIONS AND DURATION OF APPOINTMENT

A. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Directors. The Board shall act on appointments and reappointments only after there has been a recommendation from the Credentials Committee and the Medical Executive Committee ("MEC") in accordance with the provisions of these Bylaws and the Credentialing Policy.

B. Appointments to the Staff will be for no more than twenty-four (24) calendar months.

C. Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with the Credentialing Policy.

2.4 STAFF DUES

A. Annual Medical Staff dues shall be governed by the most recent action recommended by the MEC.

B. Emeritus Staff members will not be required to pay dues.

C. Dues shall be payable annually by March 31st. A practitioner's failure to pay dues shall be deemed a voluntary resignation from the Staff.

2.5 RESPONSIBILITIES OF STAFF MEMBERSHIP

Each Staff member shall:

1. Direct the care of his or her patients and will supervise the work of any Allied Health Professionals under his/her supervision;

2. Assist the Hospital in fulfilling its responsibilities for providing emergency and charitable care;

3. Assist other physicians in the care of their patients when reasonable and appropriate;

4. Act in an ethical, professional and courteous manner;

5. Act in accordance with the Ethical and Religious Directives for Catholic Health Care Services with regard to his or her practice at the Hospital;

6. Treat employees, patients, visitors, and other physicians in a dignified and courteous manner.

2.6 INITIALCREDENTIALING/APPOINTMENTAND RECREDENTIALING/ REAPPOINTMENT

2.6.1 Initial Credentialing

Procedures for initial credentialing involve the completion of an initial application and verification of information from primary sources and secondary sources. This will include a valid state license, education and training records, and Board Certification status. Additional procedures are set forth in the Saint Francis Healthcare (SFH) Credentialing Policy.

2.6.2 Appointment

The Medical Staff follows a detailed process for evaluating requests for appointment, reappointment and clinical privileges to the Medical Staff. Applicants are required to submit a complete application to the Medical Staff Services Office. The information is verified and evaluated by a credentialing specialist. After verification of credentials, review and interview by the pertinent department(s), the department chair(s) shall transmit a recommendation regarding the applicant's appointment and clinical privileges to the Credentials Committee and then to the Medical Executive Committee. All applicants for appointment to the Medical Staff and delineated clinical privileges must be approved by the Board. Initial appointments to the Medical Staff and initial awards of clinical privileges shall be subject to focused professional practice evaluation (FPPE). Details regarding the specific procedures for credentialing and appointment to the Medical Staff are set forth in the SFH Credentialing Policy.

2.6.3 Recredentialing

The procedures for recredentialing involve the completion of a renewal application. Licensure, Board Certification, and NPDB must be re-verified from primary sources. The recredentialing process will also include review of performance indicators. Additional procedures are set forth in the SFH Credentialing Policy.

2.6.4 Reappointment

Medical Staff members who wish to renew their staff membership and/or clinical privileges must complete a renewal application. Once the information is verified and evaluated by a credentialing specialist, the department chair shall transmit a recommendation regarding the applicant's reappointment and clinical privileges to the Credentials Committee and then to the Medical Executive Committee. All reappointments and clinical privileges must be approved by the Board. Details regarding the specific procedures for credentialing and appointment to the Medical Staff are set forth in the SFH Credentialing Policy.

2.7 GRANTING OF CLINICAL PRIVILGES

2.7.1 Request for Clinical Privileges

Consideration of request for Clinical Privileges, whether initial or additional, shall be evaluated using a process similar to that for appointment and reappointment to the Medical Staff. Details regarding the specific procedures for credentialing and appointment to the Medical Staff are set forth in the SFH Credentialing Policy.

2.7.2 Temporary Privileges

As recommended by the President of the Medical staff or his/her designee (the pertinent Department Chair), temporary clinical privileges may be granted by the CEO or his/her designee but only in the following limited circumstances:

A. Pendency of Application- for no longer than 120 days while awaiting completion of the credentialing process; and

B. Patient Care Need - when there is an important patient care, treatment, or service need for no longer than 120 days.

Details regarding the specific procedures for granting Temporary Privileges are set forth in the SFH Credentialing Policy.

2.7.3 Emergency Privileges

In emergency situations, a member of the Medical Staff may consult and treat a patient -during emergency only- to the extent permitted by his or her license regardless of department assignment or clinical privileges. Details regarding the specific procedures for granting Emergency Privileges are set forth in the SFH Credentialing Policy.

2.7.4 Disaster Privileges

When the SFH disaster plan has been implemented and it is likely that SFH will have difficulty meeting the needs of patients, a modified credentialing process may be applied to grant disaster privileges to eligible licensed independent practitioners. Details regarding the specific procedures for granting Disaster Privileges are set forth in the SFH Credentialing Policy.

2.8 PEER REVIEW ACTION

2.8.1 Collegial Intervention

Collegial Intervention encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. The relevant Medical Staff leader(s) (Officers, applicable Committee and Department Chairpersons and the VPMA/CMO) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation. Details regarding the Collegial Intervention procedure are set forth in the SFH Credentialing Policy.

2.8.2 Precautionary Suspension or Restriction of Clinical Privileges

The Chair of the Board of Directors, the Chief Executive Officer or designee, the VPMA/CMO, and the Department Chairpersons shall each have the authority to suspend or restrict all or any portion of the clinical privileges of a Medical Staff member or other individual whenever failure to take such action may result in an **imminent danger** to the health and/or safety of any patient or other individual. Such precautionary suspension or restriction shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the matter that precipitated the suspension or restriction. The individual may be afforded an opportunity to voluntarily refrain from exercising privileges pending an investigation. Details regarding the Precautionary Suspension or Restriction of Clinical Privileges procedure are set forth in the SFH Credentialing Policy.

2.8.3 Automatic Relinquishment

The admitting and clinical privileges of any Medical Staff appointee shall be deemed to be automatically relinquished under the following circumstances:

1. failure to complete medical records
2. state termination or revocation of medical license
3. state revocation of controlled substance registration
4. failure to be adequately insured
5. failure to provide requested or required information
6. Medicare or Medicaid violations

7. Criminal activity

Any physician whose Medical Staff membership, admitting or clinical privileges, for any reason, are deemed to be automatically relinquished or who is deemed automatically ineligible for reappointment, shall not be entitled to procedural rights (a hearing or appellate review) under the Fair Hearing Plan. Details regarding the Automatic Relinquishment procedure are set forth in the SFH Credentialing Policy.

2.8.4 Fair Hearing

The following recommendations or actions, if deemed adverse pursuant to Section 1.2 of the Fair Hearing Plan, shall entitle the practitioner affected thereby to a hearing upon a timely and proper request:

1. denial of initial Staff membership;
2. denial of reappointment;
3. suspension of staff membership; (other than Precautionary Suspension);
4. revocation of staff membership;
5. reduction of staff category;
6. restriction of admitting prerogatives;
7. denial of requested clinical privileges, and
8. reduction, restriction, suspension or revocation of clinical privileges.

When any of the above circumstances exist, the Applicant or Staff member will be notified of the recommendation or action and afforded an opportunity to request a hearing. The notice shall state that an adverse action has been proposed to be taken involving the practitioner; a general description of the proposed action and the reasons for the proposed action; that the practitioner has the right to request a hearing on the proposed adverse action in accordance with the Medical Staff Bylaws and this Fair Hearing Plan; that the practitioner has thirty (30) days after receiving the Notice within which to request a hearing; a copy of the Fair Hearing Plan; that, after receipt of his hearing request, the practitioner will be notified of the date, time and place for the hearing; and that failure to request a hearing within the specified time period shall constitute a waiver of his or her rights to a hearing and to an appellate review on the matter. The procedures of the fair hearing and appeal process are set forth in detail in the SFH Fair Hearing Plan.

ARTICLE III
CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board of Directors and shall be designated as one of the categories of the Staff listed below. All Medical Staff appointees shall be assigned to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and the Credentialing Policy and approved by the Board of Directors.

- Medical staff categories will automatically be changed based on activity level.

3.1 ACTIVE STAFF

3.1.1. Qualifications

The Active Staff shall consist of those physicians, dentists and podiatrists who have demonstrated an interest in and commitment to the Hospital through both patient care activities and Hospital and Medical Staff service, and who:

1. Continuously meet the full requirements and qualifications for appointment and reappointment as noted in Section 2.2 of these Bylaws and described in the Credentialing Policy.

2. Are located (office and residence) close enough to the Hospital to fulfill their Medical Staff responsibilities and provide timely and continuous care for their patients in the Hospital, in accordance with those specific requirements that are recommended by the MEC and approved by the Board of Directors.

3. Have a minimum of twelve (12) patient encounters at the Hospital during each 2-year reappointment cycle. (Failure to have the required twelve (12) patient encounters in a reappointment cycle shall render the appointee ineligible to apply for reappointment to the Active Staff. Such appointee shall be automatically reassigned to the Associate or Community Staff category).

4. Participate in Continuing Medical Education programs as required by the MEC.

3.1.2 Prerogatives

Active Staff members shall be:

1. Entitled to admit and treat patients within the limits of their assigned clinical privileges;

2. Eligible to vote at Medical Staff and applicable department, section, and committee meetings; and,

3. Eligible to hold office in the Medical Staff organization (as Medical Staff officers, department chairpersons, section directors and Committee chairs).

3.1.3 Responsibilities

Active Staff members shall assume the following functions and responsibilities:

1. Fulfilling the basic responsibilities of Medical Staff membership set forth in Section 2.5. of these Bylaws.

2. Caring for unassigned ("service") patients.

3. Accepting emergency service calls, as assigned by the Hospital.

4. Participating in quality assessment, performance improvement, and monitoring activities including the evaluation of provisional appointees.

5. Serving on Medical Staff committees.

6. Vote of Medical Staff committees.

7. Paying Medical Staff dues.

3.2 ASSOCIATE STAFF

3.2.1 Qualifications

Associate Staff members must continuously meet the full requirements and qualifications for Medical Staff membership as noted in Section 2.2 of the Bylaws and as described in the Credentialing Policy.

1. Have 1-11 patient encounters at the Hospital during each 2-year reappointment cycle. (Failure to have the required one - eleven (1-11) patient encounters in a reappointment cycle shall render the appointee ineligible to apply for reappointment to the Associate Staff. Such appointee shall be automatically reassigned to the Community Staff category).

3.2.2 Prerogatives and Restrictions

A. Associate Staff members shall be entitled to:

1. Admit and treat patients within the limits of their assigned clinical privileges and their professional licensure.

2. Serve on Medical Staff committees.

3. Vote on Medical Staff committees.

4. Attend Medical Staff and Hospital education programs.

B. Associate Staff members shall not be entitled to:

1. Hold Medical Staff office; serve as Department Chairpersons, Section Directors, or committee chairpersons.

2. Vote at Medical Staff meetings.

3.2.3. Responsibilities

Associate Staff members shall assume the following functions and responsibilities:

1. Fulfilling the basic responsibilities of Staff membership set forth in Section 2.5. of these Bylaws.

2. Participating in Quality/Risk/Utilization Review and Improvement Programs.

3. Pay Medical Staff dues.

3.3. EMERITUS STAFF

3.3.1 Qualifications

The Emeritus Staff shall consist of those physicians who were members of the Medical Staff of Saint Francis Healthcare but who have retired from active practice.

3.3.2 Prerogatives and Restrictions

A. Emeritus Staff members shall be entitled to attend Staff and Hospital education programs.

B. Emeritus Staff members may not admit or attend patients in the Hospital.

C. Emeritus Staff may serve on Medical Staff committees.

D. Emeritus Staff members shall not be entitled to hold office in the Medical Staff organization, to serve as Department Chairpersons or Section Directors or to vote at Medical Staff, Department, Section or Committee meetings.

E. Emeritus Staff members shall not be required to pay Medical Staff dues.

3.4 COMMUNITY STAFF

3.4.1 Qualifications

A. The Community Staff shall consist of physicians, dentists, and podiatrists desiring to be associated with Saint Francis Healthcare but who do not intend to establish an inpatient practice. Such individuals would be those professionals who are interested in the affairs of Saint Francis Healthcare and who may wish to refer patients to members of the Staff, visit such patients, and provide information to the Attending physician.

- New members applying for Community Staff category shall be appointed if requested, without fulfilling the Provisional Category requirements for patient encounters.

B. Additional qualifications include:

1. Maintain Delaware licensure.

2. Be certified by State and Federal Controlled Substances registration, as appropriate.

3. Have current professional liability insurance coverage in at least the minimum amounts specified in the Bylaws.

3.4.2 Prerogatives and Restrictions

A. May refer patients to other members of the Medical Staff for admission, evaluation and/or care and treatment as appropriate.

B. May visit their hospitalized patients, provide information to the Attending physician and review the patient's hospital medical record.

C. May attend educational programs sponsored by Saint Francis Healthcare or the Medical Staff.

D. Shall receive Medical Staff communications.

E. May serve on Medical Staff Committees and at Section and Departmental meetings

F. May not vote at meetings of the entire Medical Staff nor for any Medical Staff Bylaws changes.

G. May not be entitled to hold office in the Medical Staff organization or serve as departmental chairpersons or section directors.

H. May not admit patients, write orders, or exercise any clinical privileges at Saint Francis Healthcare.

3.4.3 Responsibilities

A. Shall submit a renewal application every two years as required by Medical Staff Bylaws.

B. Attend Medical Staff and Departmental meetings as required.

C. Pay Medical Staff dues in an amount determined by the MEC.

3.5 PROVISIONAL STAFF

3.5.1 Duration of Initial Provisional Appointment and Increased Privileges

A. All initial appointments to the Medical Staff (regardless of the category of the Staff to which the appointment is made) and all initial clinical privileges shall be provisional for a period of up to twenty four (24) months from the date of appointment or longer if recommended by the Credentials Committee.

B. All grants of increased clinical privileges to existing Medical Staff members are also provisional. The duration and supervision terms of this provisional period will be recommended by the Credentials Committee, after consulting with the appropriate Department Chairperson, and approved by the Board of Directors.

C. During the term of this provisional appointment, the individual shall be evaluated by the appropriate Department Chairpersons and by the relevant committees of the Medical Staff as to the individual's clinical competence and general behavior and conduct in the Hospital.

D. Provisional privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner if warranted.

3.5.2 Duties of Provisional Appointees

A. Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Medical Staff or the Board of Directors shall require.

B. During the provisional period, an appointee must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations attendant to his/her staff category.

C. Each provisional appointee must arrange or cooperate in the arrangement of at least eight (8) patient encounters in order to attain non-provisional status. The Department Chairperson may specify the types of cases to be reviewed/observed by the appropriate Department Chairperson and/or designated proctors. Depending upon the circumstances involved, it may also be necessary for an appointee to provide information from sources other than the Hospital regarding the individual's professional performance, judgment, and clinical or technical skills, as indicated in, among other things, quality assessment and improvement activities. If this information is requested by the Department Chairperson, the appointee shall provide this information to be used in the assessment of the appointee's provisional period in the Hospital.

D. Failure of the provisional appointee during the provisional period to have eight (8) patient encounters, or failure of the appointee, during the provisional period, to fulfill all requirements of appointment relating to completion of medical records and/or cooperation with monitoring or proctoring conditions, as outlined in this Policy, shall render the provisional appointee ineligible for continued appointment and clinical privileges, unless the failure to meet these requirements is based upon good cause. In the event that, at the expiration of the provisional period, the individual is ineligible, the individual's appointment and clinical privileges shall expire without recourse to the hearing and appeal provisions of the Fair Hearing Plan. The individual shall be permitted to reapply for initial appointment in accordance with this Policy, if the individual can demonstrate to the satisfaction of the Hospital that the relevant issue has been fully resolved.

3.5.3 Prerogatives and Restrictions
Provisional Staff members shall be:

1. Entitled to admit and treat patients within the limits of their assigned clinical privileges.

2. Provisional Staff members may not vote at Medical Staff meetings.

3. Provisional Staff members shall be ineligible to hold office in the Medical Staff organization (e.g., serve as Medical Staff officers, department chairpersons, section directors or committee chairpersons).

4. Chairpersons and Directors for Departments and Sections with exclusive contracts will be allowed to hold office and serve on committees as required by contract.

3.5.4 Responsibilities
Provisional Staff members shall assume the following functions and responsibilities:

1. Fulfilling the basic responsibilities of Medical Staff membership set forth in Section 2.5. of these Bylaws;

2. Caring for unassigned ("service") patients;

3. Accepting emergency service calls, as assigned by the hospital;

4. Participating in Quality Assessment, Performance Improvement, and monitoring activities;

5. Serving on committees; and

6. Paying Medical Staff dues.

ARTICLE IV
MEDICAL STAFF OFFICERS AND VICE PRESIDENT OF MEDICAL AFFAIRS/CHIEF MEDICAL OFFICER

4.1 OFFICERS OF THE MEDICAL STAFF

The Officers of the Medical Staff shall be the President, the Vice President, the Secretary, and the Treasurer.

4.2 QUALIFICATIONS OF MEDICAL STAFF OFFICERS

Officers must be members in good standing of the Active Medical Staff at the time of nomination and election, and must remain members in good standing during their terms of office. Officers may not simultaneously hold leadership positions on another hospital medical staff.

4.3 ELECTION OF MEDICAL STAFF OFFICERS

A. Officers shall be elected at the annual meeting of the Medical Staff. All officers must be confirmed by the Board of Directors.

B. The Nominating Committee shall prepare a slate of nominees for each office, present the slate to the MEC, and post the list at least 30 days prior to the annual meeting.

C. Nominations for officer positions may also be made by a petition signed by at least 10 members of the Active Staff. Such petition must be submitted to the MEC at least 15 days prior to the annual Medical Staff meeting. In order to be included on the ballot as a candidate, each nominee must possess all the qualifications set forth in Section 4.2.

D. The candidate who receives a majority vote of those Medical Staff members eligible to vote and present at the meeting at the time the vote is taken shall be elected. In any election, if there are three (3) or more candidates for an office and no candidate receives a majority vote on the first ballot, there shall be a run-off ballot between the two (2) candidates receiving the highest number of votes.

4.4 TERM OF OFFICE

All officers shall take office on the first day of the calendar year and shall serve a period of two (2) years.

4.5 VACANCIES IN OFFICE

In the event that the President is unable to fulfill the term of office for any reason, the Vice-President shall be appointed President. Vacancies in other officer positions shall be filled by the MEC for the remainder of the Officer's term.

4.6 DUTIES OF MEDICAL STAFF OFFICERS

4.6.1. President of the Medical Staff

The President of the Medical Staff shall serve as the Chief Administrative Officer of the Medical Staff and shall perform the following duties:

1. Serve as the Chair of the MEC (call, preside at, and be responsible for the agenda at MEC meetings and business meetings);

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

3. Make appointments of Committee members and Chairs for all standing and special Medical Staff committees, except as otherwise provided in these bylaws;

4. Provide guidance on the overall medical policies of the Hospital and enforce the Bylaws, Rules and Policies of the Hospital and Medical Staff;

5. Work with the Medical Staff and Administration to implement systems that will enhance utilization of resources for providing care to patients;

6. Represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the Staff to the Vice President of Medical Affairs, the Chief Executive Officer and the Board of Directors;

7. Consult on medical matters with the Vice-President for Medical Affairs ("VPMA")/Chief Medical Officer ("CMO"), the Chief Executive Officer, and the Board of Directors; and

8. Perform such other duties commensurate with his/her office as may from time to time be reasonably necessary for the benefit of the Medical Staff.

4.6.2 Vice President of Medical Staff

The Vice President of Medical Staff shall be the President-elect of the Medical Staff and shall perform the following duties:

1. In the absence of the President, shall assume all of his/her duties and have all of his/her authority;

2. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him or her by the President of the Medical Staff; and

3. Serve as the Chair of the New and Investigative Activities Committee.

4.6.3 Secretary of the Medical Staff

The Secretary of the Medical Staff shall perform the following duties:

1. Keep accurate and complete minutes of all MEC and Medical Staff meetings;

2. Call meetings on order of the President of the Medical Staff;

3. Attend to all correspondence;

4. Present the report of the MEC at the annual Medical Staff meetings;

5. Receive and retain reports of all Medical Staff committees; and

6. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him or her by the President or Vice-President of the Medical Staff.

4.6.4 Treasurer of the Medical Staff

The Treasurer of the Medical Staff shall perform the following duties:

1. Collect staff dues and funds;

2. Make disbursements authorized by the MEC or its designee;

3. Submit a complete and detailed written stewardship report quarterly at the MEC meetings;

4. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him or her by the President or Vice-President of the Medical Staff.

4.7 REMOVAL OF OFFICERS

A. The Medical Staff may initiate the removal of an Officer by submitting a petition to the MEC signed by 10% of the Active Staff members. The MEC shall call a special meeting of the Medical Staff solely to address the petition. The Officer shall be removed if removal is supported by ballots from two-thirds of the Active Staff present and voting at the special meeting.

B. The MEC, by a two-thirds vote, may remove any Medical Staff Officer if that individual exhibits conduct that is detrimental to the interests of the Hospital or Medical Staff or if the Medical Staff officer is suffering from a physical or mental infirmity that prevents the individual from fulfilling the duties of that office.

C. If removal is being considered by the Medical Staff or the MEC, the Officer in question must be provided with written notice of the meeting at which such action is scheduled at least ten (10) days prior to the date of the meeting. The Medical Staff officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

4.8 VICE PRESIDENT OF MEDICAL AFFAIRS ("VPMA")/CHIEF MEDICAL OFFICER ("CMO")

4.8.1 Qualifications

The VPMA/CMO shall be a Board Certified physician who is qualified by experience and/or training to participate in medically-related professional and administrative aspects of the Hospital.

4.8.2 Appointment and Duties

The VPMA/CMO shall be appointed by the Board and his/her duties shall be designated by the Board. The Medical Director's term of office shall be governed by his/her employment contract with the Hospital.

4.8.3 Medical Staff Membership and Prerogatives

The VPMA/CMO, a member of the Administrative Staff of the Hospital, shall be (or become) a member of the Medical Staff. The VPMA/CMO shall be an ex-officio member without vote of all committees of the Medical Staff.

ARTICLE V
DEPARTMENTS AND SECTIONS

5.1 ORGANIZATION AND FUNCTIONS OF DEPARTMENTS AND SECTIONS

5.1.1 Functions of Departments and Sections

Each department and/or section shall:

1. Assist in the development of privileging criteria;

2. Participate in monitoring the quality of patient care and in the performance improvement program.

5.1.2 Organization of Departments and Sections

The Medical Staff shall be organized into the following departments and sections:

1. Anesthesiology
2. Emergency Medicine
3. Family Medicine
4. Internal Medicine
    a. Allergy
    b. Cardiology
    c. Dermatology
    d. Endocrinology & Metabolism
    e. Gastroenterology
    f. Hematology/Oncology
    g. Hospitalist Medicine

h. Infectious Diseases
i. Nephrology
j. Neurology
k. Pain & Palliative Care
l. Physical Medicine & Rehab
m. Psychiatry
n. Pulmonary Diseases
o. Rheumatology

5. Obstetrics and Gynecology

6. Pathology and Laboratory Medicine

7. Pediatrics

   a. Neonatology

8. Radiology

   a. Radiation Oncology

9. Surgery
   a. Acute Surgical Services
   b. Bariatric Surgery
   c. Cardiothoracic Surgery
   d. General Surgery
   e. Neurosurgery
   f. Ophthalmology
   g. Oral & Maxillofacial Surgery
   h. Orthopedics
   i. Otolaryngology
   j. Plastic and Reconstructive Surgery
   k. Podiatry
   l. Urology
   m. Vascular Surgery

5.2 ASSIGNMENTS TO DEPARTMENTS

A. Each member of the Staff shall be assigned membership in at least one Department, but may be granted membership and/or clinical privileges or specified services in one or more of the other Departments or Sections. The MEC, after consideration of the recommendations of the Chairperson of the appropriate Clinical Departments and Sections as transmitted to the Credentials Committee, shall recommend to the Board of Directors Department assignments for all Medical Staff members in accordance with their qualifications.

B. The exercise of clinical privileges or the performance of specified services within any Department shall be subject to the rules and regulations of the pertinent Department and/or Section and the authority of the Department Chairperson and/or Section Director.

5.3 DEPARTMENT CHAIRPERSONS

5.3.1 Qualifications of Department Chairpersons

Each Department Chairperson shall be a member of the Active Staff, shall have demonstrated ability in at least one (1) of the clinical areas covered by the Department, shall be Board Certified in an appropriate specialty (or otherwise determined by the MEC to possess equivalent qualifications) and be willing and able to discharge the functions of his/her office.

5.3.2 Selection of Department Chairpersons

A. The Chairpersons of the Departments of Surgery, Internal Medicine, Family Medicine, Obstetrics and Gynecology, Pediatrics, and Psychiatry shall be appointed by the President of the Medical Staff after consultation with the following individuals: Medical Staff officers, VPMA/CMO, and five (5) representatives who are members of the pertinent Department. The Department representatives will be volunteers. If more than five (5) members volunteer, the MEC will select the five (5) representatives by ballot.

B. The Chairpersons of the Departments under contract with the Hospital (currently, Anesthesiology, Pathology, Emergency Medicine, and Radiology) will be appointed in accordance with the provisions of contracts.

C. The Chairpersons of all Departments must be approved by the Chief Executive Officer and the Board of Directors.

5.3.3 Term of Office, Removal and Vacancies

A. Department Chairpersons shall serve a two-year term and shall be eligible to succeed him or herself in office.

B. Department Chairpersons may be removed from office by a two-thirds vote of the Active Staff members of the department or by the Board of Directors after a Joint Conference with representatives of the MEC.

C. If a vacancy occurs in a Department Chairperson position, the President of the Medical Staff shall name an Acting Chairperson until a new Director is appointed in accordance with the provisions of Section 5.3-2 above.

5.3.4 Duties of Department Chairpersons

Each Department Chairperson shall perform the following duties:

1. Clinically related activities of the Department;

2. Establish, together with the Medical Staff and Administration, the type and scope of services required to meet the needs of patients and the Hospital;

3. Participate in the strategic planning activities for development of the Department;

4. Build upon the reputation of the Hospital, support and improve programs within the Hospital;

5. Recommend sufficient numbers of qualified and competent persons to provide care or services;

6. Recommend space and other resources needed by the Department;

7. Assume responsibility for all clinically and administratively related activities of the Department;

8. Integrate and coordinate interdepartmental and intra-departmental services;

9. Integrate the Department or service into the primary functions of the organization;

10. Recommend to the Medical Staff criteria for clinical privileges that are relevant to the care provided by the Department;

11. Recommend specific clinical privileges for each Department member;

12. Determine the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care services;

13. Assess and improve the quality of care and services provided in the Department;

14. Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment and services not provided by the Department or the organization;

15. Lead in the implementation of ongoing quality monitoring of blood usage, drug usage, operative and other procedures, and medical record documentation;

16. Support hospital-wide performance improvement initiatives;

17. Maintain quality control programs, as appropriate;

18. Provide continuous surveillance of the professional performance of all individuals within the department who have delineated clinical privileges;

19. Develop and implement policies and procedures that guide and support the provision of services within the department;

20. Plan, develop, organize and manage departmental orientation and continuing education for all persons in the department;

21. Recommend to the MEC an appropriate person to be the Director of each Section in his/her Department, if any; and

22. Enforce the Medical Staff Bylaws, Rules and Regulations within the Department including initiating Peer Review and initiating corrective action.

5.4. SECTION DIRECTORS

5.4.1 Qualifications

Section Directors must meet the same qualifications as Department Chairpersons, which are set forth in section 5.3.1

5.4.2 Selection of Section Directors

Section Directors shall be appointed by the Chairperson of the pertinent Department after consultation with the President of the Medical Staff and the VPMA/CMO.

5.4.3 Term of Office, Removal, Vacancies

A. Section Directors shall serve a two-year term and shall be eligible to succeed him or herself in office.

B. A Section Director may be removed from office by the pertinent Department Chairperson.

C. If a vacancy occurs in a Section Director position, the Chairman of the pertinent Department shall name an Acting Director until a new Director is appointed in accordance with Section 5.4.2. above.

5.4.4 Duties of Section Directors
Each Section Director shall perform the following duties:

1. Assist the Department Chairperson in all administratively and clinically related activities;

2. Provide advice to Chairperson on area of expertise.

ARTICLE VI
COMMITTEES

6.1 GENERAL PROVISIONS

A. The Medical Staff shall have the committees described in this Article and such other committees that may be established from time to time by the Staff. Each Active Staff member is encouraged to serve on at least one Staff committee.

B. Unless otherwise prescribed by these Bylaws, the President of the Medical Staff shall appoint the Members and Chairpersons of the various Committees.

C. Unless otherwise prescribed by these Bylaws, the Chairperson and Members of each Medical Staff committee shall serve a two-year term and may be reappointed for an unlimited number of additional terms. All appointed members of committees may be removed and vacancies filled at the discretion of the President of the Medical Staff.

D. The President of the Medical Staff, the VPMA/CMO and the Chief Executive Officer shall be members, *ex officio*, without vote, on all Committees.

E. Committee Chairpersons: Only those Active Staff members who satisfy the following criteria shall be eligible to serve as Committee Chairpersons:

1. Are appointed to and in good standing on the Active Medical Staff and continue so during their term of office;

2. Have no adverse recommendations concerning staff appointments or clinical privileges;

3. Have demonstrated interest in maintaining quality medical care;

4. Have constructively participated in Medical Staff affairs, including Peer Review activities;

5. Have actively served on at least two (2) Medical Staff committees;

6. Are knowledgeable concerning the duties of the position and are willing to discharge faithfully the duties and responsibilities of the position;

7. Possess and have demonstrated ability for harmonious interpersonal relationships.

F. All committees of the Medical Staff shall keep permanent records of their actions and regularly transmit reports on the same to the MEC; and

G. Committee members shall, at all times, maintain confidentiality with regard to Credentialing, Peer Review and Performance Improvement activities.

6.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

6.2.1 Composition

A. The MEC shall consist of the Officers of the Medical Staff, all Department Chairpersons, the Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer of the Hospital, the VPMA/CMO, the Chairperson of the Credentials Committee and two Members-at-Large from the Staff.

B. Selection and Term of At-Large-Members: The Nominating Committee shall nominate four (4) candidates to serve as Members-at-Large of the MEC. The MEC shall select two (2) of the four (4) nominees to serve. Members at large shall serve staggered two-year terms so that only one (1) Member-at-Large shall be elected each year.

C. The President of the Medical Staff shall be Chairperson of the MEC and the Secretary of the Medical Staff shall serve as Secretary of the Committee.

D. The Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer and VPMA/CMO shall be *ex officio* members of the Committee, without vote.

6.2.2 Duties

The MEC shall perform the following duties:

1. Represent and act on behalf of the Medical Staff between meetings of the organized Medical Staff within their scope of responsibility;

2. Coordinate the activities and general policies of the Medical Staff;

3. Receive and act upon committee reports;

4. Implement policies of the Medical Staff not otherwise the responsibility of the Departments;

5. Provide a liaison between the Medical Staff and the Chief Executive Officer;

6. Recommend action to the Chief Executive Officer on medico-administrative matters;

7. Make recommendations on Saint Francis Healthcare management matters (for example, long-range planning) to the Board of Directors;

8. Ensure that the Medical Staff is kept abreast of the Accreditation Program and informed of the accreditation status of the Hospital;

9. Fulfill the Medical Staff organization's accountability to the Board of Directors for the medical care of patients in the Hospital;

10. Review the report of the Credentials Committee on all applicants and make recommendations for Staff membership, Department assignments, and delineation of clinical privileges;

11. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges;

12. Report at each general staff meeting'

13. Assessing and recommending off site sources not provided by the Department or organization on an annual basis;

14. Ensure that there will always be medical staff representation and participation in any deliberation affecting the discharge of Medical Staff responsibilities;

15. Ensure that there is consistency between the Medical Staff Bylaws, Rules and Regulations and Policies and the Governing Body's Bylaws;

16. Recommends clinical services to be provided by telemedicine;

17. Recommends Medical Staff membership termination;

18. Recommends to the Board the structure of the Medical Staff; and

19. Recommends to the Board the process used to review credentials and delineate privileges.

6.2.3 Staff Functions Coordinated by the MEC

The MEC will assign committees as necessary to perform the following functions:

1. Monitor, evaluate and improve care provided in, and develop clinical policy for, special care areas such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine, and anesthesia; and emergency, outpatient, home care and other ambulatory care services;

2. Conduct or coordinate quality, appropriateness and improvement activities, including invasive procedures, blood usage, drug usage reviews, medical record and other reviews; medical assessment and treatment efficiency of clinical practice patterns;

3. Conduct or coordinate utilization review activities;

4. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs, and supervise the Hospital's professional library services;

5. Develop and maintain surveillance over drug utilization policies and practices;

6. Investigate and control nosocomial infections and monitor the organization's infection control program;

7. Plan for response to fire and other disasters, for organizational growth and development, and for the provision of services required to meet the needs of the community;

8. Direct staff organizational activities, including staff bylaws, review and revision, liaison with the Board of Directors and Hospital administration and Hospital accreditation;

9. Provide support for faculty and members of the Medical Staff who participate in the supervision and education of Resident Staff;

10. Coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services; and

11. Engage in other functions reasonably requested by the MEC and the Board of Directors.

6.2.4 Meetings

The MEC shall meet as often as necessary to fulfill its responsibilities. Special meetings of the MEC may be called at any time by the President of the Medical Staff.

The MEC shall maintain a permanent record of its proceedings and any actions taken.

6.3 CREDENTIALS COMMITTEE

6.3.1 Composition

A. The Credentials Committee shall consist of a Chairperson and at least six (6) other members appointed by the President of Medical Staff. At least one (1) member is to be appointed from each of the following Departments: Surgery, Obstetrics and Gynecology, and Medicine/Family Practice.

B. Members serving more than three (3) consecutive two (2)-year terms will need approval by the current President of the Medical Staff to remain on the committee.

6.3.2 Duties

The Credentials Committee shall perform the following duties:

1. Review the credentials of all applicants for initial Medical Staff appointment, reappointment and clinical privileges; make investigations of and interview such applicants as may be necessary, and make recommendations to the MEC regarding appointment, reappointment, delineated Clinical Privileges, Staff category and department;

2. Review the credentials of all Allied Health Professionals who request to practice in the Hospital, make investigations of and interview such practitioners as may be necessary, and make recommendations to the MEC regarding appointment, reappointment, and delineated Clinical privileges;

3. Review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of Allied Health Professionals practicing in the Hospital and, as a result of such review, provide a written report of its findings and recommendations;

4. Investigate the credentials of all applicants for membership (primary source verification and consultation with the Chairperson of any pertinent department and, if applicable, the director of any pertinent section) and make recommendations in conformity with the Credentialing Policy;

5. Investigate any breach of ethics that may be referred to it;

6. Review any records that may be referred to it by the MEC to arrive at a decision regarding the performance of staff members;

7. Review the status of each Staff member being reappointed, his/her medical work, and his/her responsibilities to the Staff, and make recommendations to the MEC concerning the reappointment to the Staff, change of status, and the assignment of members to services;

8. Develop, in conjunction with department chairs and section chiefs, criteria for granting Clinical Privileges, to submit to the MEC and Board for approval and use in the credentialing and privileging process; and

9. Develop credentialing policies, to submit to the MEC and Board for approval and use.

6.3.3 Meetings

The Credentials Committee shall meet at least 10 months of the year or more often if necessary to accomplish its duties. The Chairperson of the Credentials Committee shall be available to meet with the MEC and/or the Board of Directors or its Committee on all recommendations of the Credentials Committee.

6.4 NOMINATING COMMITTEE

6.4.1 Composition

The Nominating Committee will consist of five (5) members. Four (4) members shall be nominated by the Nominating Committee. No member shall serve more than two (2) consecutive 2-year terms.

6.4.2 Duties

The Nominating Committee shall nominate and present at the annual meeting of the Staff a proposed slate of candidates for general Staff officers, the Members-at-Large of the MEC, and four (4) members of the Nominating Committee.

6.4.3 Meetings

The Nominating Committee shall meet as necessary to discharge its responsibilities.

6.5 CANCER COMMITTEE

6.5.1 Composition

A. The President of the Medical Staff, with the advice of the MEC, shall appoint the Chairman and the members of the Cancer Committee.

B. The membership of this committee should include, but is not necessarily limited to, Representatives from the Department of Surgery, Medical Oncology, Diagnostic Radiology, Radiation Oncology and Pathology. The hospital will be asked to recommend Committee members from the Department of Patient Care Services, the Department of Clinical Effectiveness, the Tumor Registry, Health Information Systems, and Administration.

6.5.2 Duties

A. The Cancer Committee responsibilities include the following:

1. Develops and evaluates the annual goals and objectives for the clinical, educational and programmatic activities related to cancer;

2. Promotes and coordinates a multi-disciplinary approach to patient management;

3. Establishes and ensures educational and consultative Cancer Conferences are held regularly and cover all major sites and related issues;

4. Encourage all members of the Medical Staff to present their newly diagnosed, difficult cases for assistance in pretreatment evaluation, staging, treatment strategy and rehabilitation;

5. Ensures an active supportive care system is in place for patients, families and staff;

6. Monitors quality management and improvement through completion of quality management studies which focus on quality, access to care and outcomes;

7. Promotes clinical research;

8. Supervises the cancer registry and ensures accurate and timely abstracting, staging and follow-up reporting;

9. Performs quality control of registry data;

10. Encourages data usage and regular reporting;

11. Ensures content of the Annual Report meets requirements;

12. Publishes the Annual Report by November 1 of the following year;

13. Upholds medical ethical standards; and

14. Give surveillance to the entire spectrum of care for all cancer patients admitted to Saint Francis Healthcare encompassing diagnosis, treatment, rehabilitation, follow-up and end results reporting.

6.5.3 Meetings

A. The Cancer Committee will meet quarterly. Minutes of these meetings shall be kept in Tumor Registry and shared with the MEC.

B. The Cancer Conferences will be scheduled monthly. Cancer conference cancellations/re-scheduling must be approved by the Cancer Committee Chair or Cancer Conference Coordinator (or designee).

6.6 PEER REVIEW COMMITTEE

6.6.1 Composition

The Peer Review Committee will consist of VPMA/CMO, Chairpersons of Departments of Anesthesiology, Emergency Medicine, Medicine/Family Practice, Obstetrics and Gynecology, Pathology, Radiology and Surgery, President of the Medical Staff, Past President of Medical Staff and support staff from the Quality Department.

The VPMA/CMO will be Chairman of the Peer Review Committee**.**

6.6.2 Duties
The Peer Review Committee will perform the following duties:

1. Through the use of approved clinical indicators it will perform ongoing screening reviews relating to corporate, Federal, State and departmental guidelines;

2. Coordinate ongoing review of cases referred for peer review;

3. Fulfill the Peer Review Policy as outlined in Rules and Regulations, Section L;

4. Make recommendations for individual, departmental or hospital-wide performance improvement activity;

5. The Peer Review Committee reports activities and decisions to the MEC for final action:

6. Peer Review Committee shall delegate matters related exclusively to behavioral and non-clinical issues to the Professional Review Committee, a subcommittee of the Peer Review Committee. This subcommittee shall be comprised of members of the Peer Review Committee and report matters reviewed, findings and recommendations to the Peer Review Committee. The Chair of the Professional Review Committee will be a non-peer review committee medical staff physician, Chair of the Department of the person in review and second non-peer review medical staff physician. If the Chair of the Professional Review Committee is involved in the review, the President of the Medical Staff will act in place of the Chair.

7. Matters, clinical and non-clinical, appropriate for reporting to State Board of Medical Licensure and Discipline shall be reported as per current State law reporting mandates.

6.6.3 Meetings
The Peer Review Committee will meet monthly and minutes will be prepared and shared with the MEC.

6.7 OTHER COMMITTEES

6.7.1 Committees of the Medical Staff

A. The standing Committees of the MEC shall include the Bylaws Committee and the Education and House Staff Committee. The members of Committees of the MEC shall be appointed by the President of the Medical Staff, shall meet as necessary to discharge their responsibilities, maintain records of their activities and actions, and shall regularly report thereon to the MEC.

B. The MEC may, by resolution and upon approval of the Board of Directors, without amendment of these Bylaws, establish additional committees to perform one (1) or more staff functions. In the same manner, the MEC may, by resolution and upon approval of the Board of Directors, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws, which is not assigned to a standing or special committee, shall be performed by the MEC.

6.7.2 Special Committees

As necessary, the MEC may establish temporary special committees. Special committees will be established for a specific defined purpose and required to report back to the Medical Staff or the MEC at a definite time.

ARTICLE VII
MEDICAL STAFF MEETINGS

7.1 MEETINGS OF THE MEDICAL STAFF

7.1.1 Annual Staff Meeting

The regular Medical Staff meeting in the last quarter of the year shall be the Annual Staff Meeting. At the Annual Staff Meeting, elections will be held for any open position(s) for Medical Staff officers.

7.1.2 Special Staff Meetings

A. Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the MEC, twenty-five percent (25%) of members of the Active Staff, or the Board of Directors.

B. The President of the Medical Staff shall designate the time and place for any special meeting. No business shall be transacted at any special meeting except that stated in the notice of the meeting.

7.2 DEPARTMENT AND COMMITTEE MEETINGS

7.2.1 Department Meetings

A. Members of each Department shall meet on a regular basis at a time and date set by the chair of the Department to review and evaluate the clinical work of the department.

B. Each Department shall maintain a permanent record of its findings, proceedings and actions, and shall report regularly to the MEC and the Chief Executive Officer.

7.2.2 Committee Meetings

A. Committees may, by resolution, provide the time for holding regular meetings without notice other than the resolution.

B. Each committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the MEC and the Chief Executive Officer.

7.2.3 Special Department and Committee Meetings

A special meeting of any department or committee may be called by or at the request of the pertinent chairperson.

7.3 QUORUM

A. There shall be no quorum requirements for Medical Staff and Department meetings. For Departments, the quorum requirement shall be ten percent (10%) of the Department for policy decisions. For Committee meetings, the quorum requirement shall be fifty percent (50%) of the Committee.

B. Once a quorum is established, the business of the meeting may continue and all actions shall be binding even if less than a quorum exists at a later time in the meeting.

C. Departments may use mail ballots for voting on major policy issues.

7.4 NOTICE OF MEETINGS

Reasonable notice of all meetings of the Medical Staff and regular meetings of Departments and Committees shall be delivered, either in person or by mail, to each Medical Staff member. A single notice of all meetings shall be sufficient. Such notice shall state the date, time and place of the meeting. The attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting.

7.5 ATTENDANCE REQUIREMENTS

A. Members of the Active Staff are strongly encouraged to attend applicable Medical Staff, department and committee meetings each year.

B. Members of the MEC and the Credentials Committee are expected to attend at least fifty percent (50%) of the meetings held.

C. Any Medical Staff appointee whose clinical work is scheduled for discussion at a regular Department meeting shall be given special notice and shall be expected to attend such meeting. In the special notice, the Chairperson of the Department shall give the individual advance written notice of the time and place of the meeting and state that his or her attendance is mandatory. Whenever apparent or suspected deviation from standard clinical practice is involved, the special notice to the individual shall so state. Such special notice shall be given by certified mail, return receipt requested.

D. An individual given special notice of a meeting may make a timely request to the Chairperson of the Committee or Department for postponement or rescheduling of the meeting. Such a request must be supported by an adequate showing that the individual's absence will be unavoidable. If such a timely request is not made, and the individual fails to attend the required meeting, the Chairperson of the applicable Department or Committee shall notify the President of the Medical Staff. Unless excused by the President of Medical Staff, upon showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the individual's clinical privileges as the President of the Medical Staff shall direct. Such relinquishment shall remain in effect until the practitioner attends the pertinent meeting.

7.6 EXECUTIVE SESSION

Any person may attend meetings of the Staff, Departments, Sections and Committees. An Executive Session may be called by the Staff President, the Department Chairperson, Section Director or Committee Chairperson at any time during the meeting. During an Executive Session, only members of the Staff, Department, Section or Committee, as pertinent, may be present and all matters discussed shall be confidential. Executive Sessions shall not be used unreasonably to impair the access of Board and Hospital representatives to Staff concerns and actions.

ARTICLE VIII
ADOPTION AND AMENDMENT OF THE BYLAWS

8.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, adopt and recommend to the Board Medical Staff Bylaws, Rules and Regulations and Policies. The Medical Staff Bylaws, Rules and Regulations and Policies, the Bylaws of the governing body and the hospital policies are compatible with each other and compliant with governing laws and regulations. The Medical Staff complies with the Medical Staff Bylaws, Rules and Regulations and Policies. The Medical Staff enforces the Medical Staff Bylaws, Rules and Regulations and Policies by recommending action to the governing body in certain circumstances and taking action in others. The governing body upholds the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the governing body. The Medical Staff shall review the Bylaws at least annually and propose them directly to the governing body. The Medical Staff Bylaws and any amendments thereto, shall be effective when approved by the Board.

8.2 METHODS OF AMENDMENT OF THE MEDICAL STAFF BYLAWS

A. The Medical Staff adopts and amends Medical Staff Bylaws. Adoption or amendments of Medical Staff Bylaws cannot be delegated. After adoption or amendment by the Medical Staff, the proposed Bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval.

B. If the voting members of the Medical Staff propose to adopt a Rule, Regulation, or Policy, or an amendment thereto, they first communicate the proposal to the MEC. If the MEC proposes to adopt a Rule or Regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff; when it adopts a policy or an amendment thereto, it communicates this to the Medical Staff. Amendments to these Bylaws may be proposed by a petition signed by twenty five percent (25%) of the voting members of the active Medical Staff, by the Bylaws Committee, or by the MEC.

C. All proposed amendments must be reviewed by the MEC prior to a vote by the active Medical Staff. The MEC shall provide notice of all proposed amendments, including amendments proposed by a petition of the voting members of the Medical Staff as set forth above, to the voting staff. The MEC may also report on any proposed amendments, either favorably or unfavorably.

D. The proposed amendments will be provided via electronic mail allowing 30 days for ballot return. Failure to respond by the defined 30 days will be considered a vote for adoption and approval. To be adopted, the amendment must receive 51% of the votes cast for adoption and approval.

E. The MEC may also present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast (51% of the votes cast).

F. The MEC shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling or other errors of grammar or expression.

G. All amendments shall be effective only after approval by the Board.

H. If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

8.3 RELATED POLICIES AND MANUALS

The MEC shall recommend to the Board of Directors related policies and procedures governing various aspects of Medical Staff governance. Such documents shall consist of the following documents:

1. Credentialing Policy
2. Fair Hearing Plan
3. Rules and Regulations

The MEC may, through the same procedure as that for adoption and amendment of the Medical Staff Bylaws, adopt other policies and procedure manuals. Upon approval by the Board, these policies and manuals shall be incorporated by reference and become part of these Medical Staff Bylaws.

8.4 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Staff shall adopt and may from time to time amend such Rules and Regulations as may be consistent with these Bylaws and as may be necessary to implement more specifically the general principles found in these Bylaws. These Rules and Regulations shall relate to the proper conduct of Staff organizational activities as well as define the level of practice that is to be required of each Staff member or dependent health care practitioner in the Hospital. The Rules and Regulations shall not be part of these Bylaws. They shall be reviewed at least annually by the Bylaws Committee and the MEC.

8.5 COMMUNICATION

As a mechanism of communication between the Medical Staff, Hospital, and Governing Board two (2) avenues of communication will be established: 1) all activities of the MEC as recorded in their minutes shall be reviewed by the Governance Committee of the Board. The Governance Committee will then report to the Governing Board regular activities of the Medical Staff including Credentials, Bylaw changes, and other clinical activities. In return, concerns of the Board will be relayed back to the MEC by the CEO who is a member of the MEC. 2) besides written communication, representation on the Governing Board will be provided through attendance of the President of the Medical Staff or his/her designee.

Any issues requiring greater participation of both the MEC and Governing Board can be handled by a Joint Conference as outlined in the next Section 8.6.

8.6 JOINT CONFERENCE AMENDMENT

If the Board of Directors has determined not to accept a recommendation submitted to it by the MEC, the MEC is entitled to a Joint Conference between the Officers of the Board and the Officers of the Medical Staff. Such Joint Conference shall be for purposes of further communicating the Board's rationale for its contemplated action, and to permit the officers of the Medical Staff to fully articulate the rationale for the Medical Staff's recommendation. Such a joint conference shall be scheduled by the Chief Executive Officer within two weeks after receipt of a request for a joint conference from the President of the Medical Staff.

8.7 ADOPTION OF MEDICAL STAFF BYLAWS

These Medical Staff Bylaws are adopted and made effective upon approval of the Board of Directors, superseding and replacing any and all previous Medical Staff Bylaws. Henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges shall be taken under and pursuant to the requirements of these Bylaws.

8.8 CONFLICT MANAGEMENT PROCESS

A. When there is a conflict between the Medical Staff and the MEC with regard to: (a) proposed amendments to the Medical Staff Rules and Regulations, (b) a new policy proposed by the MEC, or (c) proposed amendments to an existing policy that is under the authority of the MEC, a special meeting of the Medical Staff will be called in accordance with the process for calling special meetings. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to strive to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the governing body on a Rule, Regulation, or Policy adopted by the Medical Staff or the MEC. The governing body determines the method of communication.

B. If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

8.9 URGENT AMENDMENT PROCESS

The MEC and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation. The MEC voting members of the Medical Staff may provisionally adopt and the governing body may provisionally adopt and provisionally approve an urgent amendment without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff immediately. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts shall be implemented. If necessary, a revised amendment is then submitted to the governing body for action.