



THE UNIVERSITY OF TOLEDO  
**MEDICAL CENTER**

**THE UNIVERSITY OF TOLEDO MEDICAL CENTER**

**BYLAWS OF THE MEDICAL STAFF**

**(Approved by UT Board of Trustees July 13, 2016)**

## TABLE OF CONTENTS

<b>ARTICLE I - PURPOSES OF THE BYLAWS .....</b>	<b>2</b>
<b>ARTICLE II - NATURE OF MEDICAL STAFF MEMBERSHIP AND DELEGATION BY BOARD ..</b>	<b>2</b>
<b>ARTICLE III - MEMBERSHIP IN THE STAFF .....</b>	<b>3</b>
<b>ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF.....</b>	<b>11</b>
<b>ARTICLE V - APPOINTMENT, REAPPOINTMENT, CHANGES IN STAFF CATEGORY AND ADDITIONAL PRIVILEGES.....</b>	<b>14</b>
<b>ARTICLE VI - SUSPENSION AND INVESTIGATION .....</b>	<b>20</b>
<b>ARTICLE VII - HEARING AND APPELLATE REVIEW PROCEDURE.....</b>	<b>26</b>
<b>ARTICLE VIII - ALLIED HEALTH PROFESSIONALS.....</b>	<b>33</b>
<b>ARTICLE IX - MEDICAL STAFF OFFICERS .....</b>	<b>36</b>
<b>ARTICLE X - CLINICAL SERVICES.....</b>	<b>39</b>
<b>ARTICLE XI - MEDICAL STAFF COMMITTEES.....</b>	<b>43</b>
<b>ARTICLE XII - MEDICAL STAFF MEETINGS .....</b>	<b>48</b>
<b>ARTICLE XIII - CLINICAL SERVICE MEETINGS .....</b>	<b>49</b>
<b>ARTICLE XIV - CONFLICT RESOLUTION .....</b>	<b>50</b>
<b>ARTICLE XV - MEDICAL STAFF POLICIES AND MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS.....</b>	<b>51</b>
<b>ARTICLE XVI - AMENDMENTS TO BYLAWS .....</b>	<b>52</b>
<b>ARTICLE XVII - DEFINITIONS, GENERAL PROVISIONS .....</b>	<b>52</b>

**ARTICLE I  
PURPOSES OF THE BYLAWS**

The *purposes* of these Bylaws are:

(a) To improve the human condition through the provision and advancement of clinical care, teaching, research and the art and science of medicine, dentistry, podiatry, and psychology;

(b) To provide procedures through which: (1) each member of the staff may obtain the full benefits of membership on the staff and the privileges of using the Medical Center's facilities and services; and (2) each member of the staff will participate in fulfilling the member's obligations to the Medical Center;

(c) To delegate to the staff the initial responsibility to account for the professional performance and ethical conduct of staff members and applicants for staff membership and privileges, subject to the authority of the Board on the consistency, efficiency, and quality of patient care in the Medical Center; and

(d) To foster high quality medical care for all patients admitted to or treated in the Medical Center and to foster a state of the art learning environment;

To provide a means through which the staff may participate in the Medical Center's policy and planning processes.

\*\*All capitalized terms have the meanings associated with them as set forth in Article XVI at the end of these Bylaws.

**ARTICLE II  
NATURE OF MEDICAL STAFF MEMBERSHIP  
AND DELEGATION BY BOARD**

(a) Membership on the Medical Staff of the Medical Center is a privilege which will be extended only to professionally-competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the staff will confer upon the member only the category of membership, clinical privileges and the prerogatives expressly requested by the member and expressly granted by the Board. The prerogatives set forth in Article IV for each staff category are general in nature and are limited by special conditions attached to appointment to privileges and to staff membership, other sections of these Bylaws, Medical Staff Policies, policies and procedures of the Medical Center and the law.

(b) By law, all of the authority of the Medical Center is vested in The University of Toledo Board of Trustees. The Board exercises that authority by generally supervising the affairs of the Medical Center; by establishing rules and regulations for the government of the Medical Center; by delegating to others, subject to the authority of the Board, responsibilities for supervising the day-to-day operation of the Medical Center and advising the Board concerning the Medical Center; and by taking actions which the Board deems advisable. The Board, through the rules and regulations for governance which it has established by these Bylaws, has delegated to the staff responsibility for advising the Board concerning the quality of patient care and matters affecting the staff, subject to the ultimate authority of the Board. The Board exercises this authority acting through its Clinical Affairs Committee, as set forth more fully in the Board's bylaws and policies.

The Board by these Bylaws delegates to the Medical Staff the duty to monitor the quality of medical care in the Medical Center, to review the professional qualifications and activities of the Medical Staff and to advise the Board accordingly, to advise the Board on the quality of medical care in the Medical Center and the activities of the Medical Staff, and to recommend to the Board an applicant's appointment or reappointment to the staff and the clinical privileges each applicant will enjoy in the Medical Center. The Board hereby authorizes and directs the Medical Staff to perform these functions through its committees, including, without limitation, the Executive Committee; the Credentials Committee; and committees mandated by The Joint Commission and the Board; and committees or services of the Medical Staff, including committees of the whole.

The Board directs the EVP for Clinical Affairs, the Chief Clinical Officer, any assistant to the Chief Clinical Officer, anyone acting in place of the Chief Clinical Officer, the officers of the Medical Staff, and the employees of the Medical Center delegated by the Chief Clinical Officer to assist the committees of the Medical Staff in fulfilling the duties and responsibilities delegated to the committees.

From time to time matters that are within the scope of the delegation of responsibility to the staff but on which the staff has not acted may come to the attention of the Board. On all such matters, the Board will take such action as it deems advisable when not inconsistent with the best interests of the Medical Center as judged by the Board, but will refer such matters to the staff through the Executive Committee for advice before taking final action.

From time to time matters that are not within the scope of delegation to the staff under these Bylaws may come to the attention of the Board. For such matters on which the Board desires the advice of the staff, the Board may request such advice through the Executive Committee and the staff through the Executive Committee will render such advice.

Referrals to the Joint Conference Committee under Section 11.4 will satisfy the requirements of this Article.

### **ARTICLE III MEMBERSHIP IN THE STAFF**

#### **3.1 Obligations.** Members of the staff will:

(a) Continuously meet the qualifications, standards, requirements, and considerations set forth in these Bylaws;

(b) Ensure that the member's patients receive continuous care at a professionally recognized level of quality and efficiency and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical, dental, or allied health practitioner who is not qualified to undertake this responsibility or who is not adequately supervised;

(c) Seek consultation whenever necessary;

(d) Perform Staff, Clinical Service, Committee, and Medical Center functions for which the member is or may become responsible;

(e) Prepare and complete in a timely manner the medical and other records for all patients whom the member admits into the Medical Center or for whom the member in any way provides care in the Medical Center;

(f) Support the mission of the Medical Center; be of good moral character and abide by all laws and ethical standards of the member's profession and the Medical Center, including without limitation those standards prescribed by the codes of ethics adopted, as applicable, by the American Medical Association, the American Osteopathic Association, the American Dental Association, the American Podiatry Association, and the American Psychological Association; abide by the standards of The Joint Commission;

(g) Promptly notify the Chief of Staff who will notify the Chief Executive Officer, Chief Clinical Officer and EVP for Clinical Affairs if the member's license to practice medicine, dentistry, podiatry or psychology or Drug Enforcement Agency registration has been voluntarily or involuntarily relinquished, suspended, revoked, restricted or surrendered; Maintain: (1) professional liability insurance meeting the minimum requirements of the Medical Center, (2) with the Medical Staff Coordinator proof satisfactory to the Credentials Committee of professional liability insurance meeting the requirements; and notify the Chief of Staff through the Medical Staff Coordinator of any termination of or change in the member's insurance coverage or carrier within five days prior to the termination or change of coverage;

(h) Within five (5) days after it occurs, notify the Chief of Staff who will notify the Chief Executive Officer, Chief Clinical Officer and EVP for Clinical Affairs of any voluntary or involuntary relinquishment, reduction, suspension, termination or limitation imposed on a member's clinical privileges at another health care facility not arising out of a failure to complete medical records in a timely manner;

(i) Submit to the Chief Clinical Officer or designee within three (3) days of receipt a copy of any quality letters regarding Medical Center patients retained in a peer review file, including inquiries or sanction recommendations, and any other related documents in a peer review file;

(j) Cooperate with the Medical Center in complying with requirements of third-party payers;

(k) Refrain from paying or receiving from another physician or health care professional any part of a fee received for professional services;

(l) Agree to be subject to Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE) policies of the Medical Staff; and

(m) Hold responsibility for the review, adoption, and amendment of the related rules, policies, and protocols developed to implement various sections of these Bylaws.

(n) Participate in and discharge their responsibilities under these Bylaws and the Rules and Regulations of the Medical Staff including, without limitation, participation in relevant continuing education programs (these must be commensurate for requirements for relicensure in Ohio), attendance at staff and service meetings, and attendance on staff and Medical Center committees.

(o) Promptly notify the Chief of Staff, who will notify the Chief Executive Officer, the Chief Clinical Officer, and EVP for Clinical Affairs if there is a change in the person's mental or physical health that affects the practitioner's ability to perform the responsibilities of staff membership and/or clinical privileges.

**3.2 Appointment.** Each appointment and re-appointment to staff and to privileges will:

- (a) Delineate the clinical privileges that the person has been granted, including specific anesthesia privileges for each person who furnishes anesthesia services and the type of supervision, if any, required;
- (b) Specify the staff category and status to which the person has been appointed;
- (c) Assign the member to a Clinical Service;
- (d) Specify any requirements of consultation, probation, and the like. Assignment to a Clinical Service will not preclude appointment to privileges in other Clinical Services.

**3.3 Qualifications for membership.**

(a) **Generally.** The qualifications by which each application for appointment or reappointment to membership on the staff and for privileges and by which each member's continued membership on the staff and enjoyment of privileges will be evaluated are set forth in this Article III. The basic qualifications set forth in Section 3.3 (b) may not be waived except as expressly provided in these Bylaws. The Medical Center and each element of the Medical Center responsible for evaluating continued exercise of privileges and membership on the staff and applications for appointment will have wide discretion in applying the qualifications set forth in Section 3.4(a).

(b) **Basic qualifications.** Each member of the staff:

- (1) Must be currently licensed to practice medicine, osteopathic medicine, dentistry, podiatry, or psychology in the State of Ohio;
- (2) Must currently meet the specific qualifications for the category of the member's membership on the staff as established by Article IV below;
- (3) Must meet any specific qualifications for the member's clinical privileges which are contained in any policy applicable to the service or services in which the member holds privileges;
- (4) Possess and provide requested information of relevant training and experience for the category of membership and clinical privileges;
- (5) Must have shown demonstrated ability and current competence in the fields covered by the member's application for membership and privileges including, if applicable, privileges to provide anesthesia services; and
- (6) Must not be: excluded from participation in any federal health care program, as defined under 42 U.S.C. §1320a-7b (f), for the provision of items or services for which payment may be made under such federal health care programs; has not been convicted (as that term is defined under 42 U.S.C. §1320a-(7)(i)) of a criminal offense related to health care; has not been convicted of any felony; the subject of a final adverse action, as such term is defined under 42 U.S.C. §1320a-7e (g).

### 3.4 Other qualifications.

- (a) **Related to the person.** Each member of the staff will:
- (1) Adhere strictly to the law and the ethics of the person's profession and the Medical Center, and will refrain from fee splitting or inappropriate inducements relating to patient referrals;
  - (2) Comply with Medical Center policies and regulations and the Bylaws and Policies of the Medical Staff;
  - (3) Work cooperatively with others;
  - (4) Participate in and perform the responsibilities imposed upon members of the staff including, without limitation, participation in relevant continuing education programs (these must be commensurate for requirements for re-licensure in Ohio) and attendance at staff, Clinical Service meetings and Medical Center committees;
  - (5) Have the physical and mental health necessary to perform the responsibilities incident to staff membership and privileges, with or without reasonable accommodation; and will submit any reasonable evidence of current ability to perform privileges, as may be requested;
  - (6) Comply with the call obligations applicable to the category of staff membership and service requirements, and assist the Medical Center in fulfilling its responsibilities for providing emergency and charitable care; and
  - (7) Be board certified in the specialty in which the member primarily practices and (if applicable) has clinical privileges at the Medical Center by an American Board of Medical Specialties (ABMS), an American Osteopathic Association (AOA) or Royal College of Physicians or Surgeons recognized board within five years of becoming a member of the Medical Staff and, for those whose membership commenced on or after April 1, 2016, within five years of completion of the relevant training, subject to the following conditions:
    - (i) Exceptions may be granted by the Executive Committee or the Board;
      - (a) If the primary specialty of the Medical Staff member is not recognized as a specialty or subspecialty board by either the ABMS or the AOA, and the member does not fit into a general certificate specialty, the member is not required to obtain an exception;
      - (b) For members for whom board certification is required, once certified by a recognized board, the Medical Staff member must remain certified by at least one recognized board as a condition for Medical Staff membership. If Medical Staff member's board certification lapses for any reason, applicant will have a grace period of two (2) years from the date of the lapse to regain board certification from a recognized board; and
      - (c) The failure of a Medical Staff member to comply with these Board certification requirements will result in the revocation of his/her Medical Staff



membership, unless an exception is granted by the Executive Committee or the Board prior to the two (2) year period from the date of the lapse for good cause.

(b) **Related to the Medical Center.** In assessing a person's qualifications for staff membership and privileges, consideration may be given to the ability of the Medical Center and Staff to provide adequate facilities and support services for the person's practice and patients, the Medical Center's image and mission in the community, the quality of medical care rendered to patients in the Medical Center, the efficiency of the Medical Center, the well-being of the Medical Center, and the person's compliance with ethical and moral standards.

**3.5 Information that may be considered.** In determining whether a particular person meets the qualifications established by this Article III, any relevant information may be considered. In evaluating each application for reappointment, changes in category or status, or additional privileges, particular attention will be given to the professional and clinical performance of the applicant at the Medical Center, based at least in part, on the findings of the FPPE or Peer Review and OPPE as set forth in Medical Staff Policy, patterns of practice, quality management programs of the staff, medical audits, utilization reviews, infection control activities, tissue reviews, medical record reviews, pharmacy and therapeutics activities and the current ability to perform the privileges requested.

**3.6 Burden of showing qualifications.** Each applicant for staff membership or privileges has the responsibility of proving that the applicant meets the qualifications for staff membership and privileges. Each member of the Staff has the responsibility of proving that the member continues to meet the qualifications for Staff membership and privileges and is required to submit any reasonable evidence of current ability to perform privileges that may be requested. No physician, dentist, podiatrist, or psychologist will be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Medical Center merely by virtue of the fact that he or she is duly licensed to practice medicine, dentistry, podiatry, or psychology in this or in any other state, or he or she is a member of some professional organization, or that he or she had, in the past, or presently has such privileges at another hospital.

**3.7 Nondiscrimination.** The Medical Center, in considering and acting on applications for staff membership or professional privileges within the scope of the applicant's respective licensure, will not discriminate against a qualified person on the basis of race, creed, color, national origin, gender, age, sexual orientation, religion, veteran status or disability.

**3.8 Terms of privileges and appointments.**

(a) **Initial appointments.** All initial appointments to privileges and to Staff will be for a term not to exceed two (2) years.

(b) **Temporary appointments.** Temporary appointments will be for the term specified by the terms of the appointment, but in no event to exceed one hundred and twenty (120) days.

(c) **Reappointments.** Reappointments to privileges and to Staff will be for a term of not more than two (2) years.

(d) **Leaves of absence.** Each staff member must notify the Service Chief in writing if he or she will be absent for vacation, sabbatical, educational purposes, or otherwise for three (3) months or more. The notice will state the reasons for the absence and the beginning and ending dates.

Each Staff member who is absent for medical or health reasons for twelve (12) weeks or more

must notify the Service Chief in writing as soon as possible. Resumption of Medical Center privileges may be contingent upon receipt of a letter from the practitioner's physician as to health status related to medical practice competency for serious medical health reasons, which will also require the agreement of the Chief Clinical Officer and Chief of Staff for resumption of privileges.

Members of the Medical Staff may apply for a leave of absence not to exceed eighteen (18) months. Reinstatement of staff privileges may be requested through the Credentials Committee without formal reapplication, and with the concurrence of the Executive Committee. If the member's normal reappointment time fell during his/her leave, it is then necessary to follow the steps for staff reappointment.

(e) **Expiration of membership and privileges.** A practitioner's membership will expire at the conclusion of the term for which the membership was granted. Similarly, a practitioner's privileges will expire at the conclusion of the term for which the privileges were granted.

(1) A practitioner's privileges and membership expire at the end of the practitioner's membership term, but may be renewed by the practitioner's applying for reappointment within the designated time period pursuant to Section 5.3;

(2) In cases in which specific privileges have been granted contingent upon meeting established objective criteria within a specific time period, the specific privileges expire when the practitioner voluntarily allows the privileges to lapse by failing to meet the established objective criteria for those privileges, such as frequency of use of the Medical Center and continuing education requirements. In such cases, the practitioner's privileges expire at the Credentials Committee meeting prior to the next regularly scheduled Executive Committee meeting following the end of the time period established by the objective criteria. At that Executive Committee meeting, the Executive Committee will review such expiration of privileges. The Chief of Staff will promptly notify the practitioner of such expiration of privileges. The practitioner may request reinstatement of the privileges when the objective criteria for those privileges have been met, which reinstatement will be processed pursuant to Section 5.4.

(3) The Credentials Committee will forward its recommendations regarding appointments and reappointments to the Executive Committee in accordance with Article V below.

(4) A practitioner whose privileges or Medical Staff membership have expired is not entitled to the rights set forth in Article VII.

(f) **Admitting privileges.** Patients may be admitted to the Medical Center only by a physician, dentist or by a podiatrist member of the Medical Staff. Psychologists may not admit patients. Allied Health Professionals authorized by law to admit patients may admit patients if granted privileges to do so.

(i) **Admissions by dentists.** A dentist may admit a patient to the Medical Center solely for the purpose of receiving dental services and will complete a dental history and physical consistent with their legal scope of practice; however, treatment not within the scope of the dentist's license will be under the supervision of a physician member of the Staff. All dental patients' records will contain a physical examination report by the dentist. It will be the responsibility of the admitting dentist to make arrangements with a physician member of the Staff to be responsible for the patient's treatment outside the scope of the dentist's license. Oral maxillofacial surgeons who admit patients without medical problems may perform the medical history and physical examination on

those patients, if granted such privileges.

(ii) **Admissions by podiatrists.** A podiatrist may admit a patient to the Medical Center solely for the purpose of receiving podiatric services and complete a podiatric history and physical consistent within their legal scope of practice; however, treatment not within the scope of the podiatrist's license will be under the supervision of a physician member of the Staff. All podiatric patients' records will contain a physical examination report by the podiatrist. It will be the responsibility of the admitting podiatrist to make arrangements with a physician member of the Staff to be responsible for the patient's treatment outside the scope of the podiatrist's license.

### 3.9 Temporary privileges.

(a) **Procedure.** Upon the written recommendations of the Service Chief where the privileges will be exercised and the Chief of Staff, the Chief Executive Officer, the Chief Clinical Officer or the EVP for Clinical Affairs may grant temporary privileges to qualified physicians, dentists, podiatrists, AHPs, who are not members of the medical staff, or psychologists who have completed an application for privileges and whose application has been verified. The application must include a request for specific temporary privileges and designate one of the following circumstances:

(i) **Pendency of application.** A qualified applicant may be granted temporary privileges for a specified period not to exceed ninety (90) days during the pendency of an application for staff membership if the applicant meets the qualifications for appointment and his/her application has been verified. Temporary privileges may not be granted to applicants for any delay in process for any reason not the fault of the Medical Center. If the practitioner's application has not been approved during the ninety (90) day period then the temporary privileges expire.

(ii) **Care of Specific Patients.** Temporary clinical privileges may be granted to a qualified physician, dentist, psychologist or podiatrist applicant to meet an important patient care need, but not more than thirty (30) days in a calendar year. Temporary privileges for care of specific patients will be forwarded upon written recommendation of the Service Chief(s) under the clinical services where the privileges will be exercised and also the written recommendation of the Chair of the Credentialing Committee provided there is verification of current licensure and current competence, and in accordance with any additional requirements as set forth in Medical Staff Policy. In order to be granted, the Chief of Staff, the Chief Executive Officer, the Chief Clinical Officer or the EVP for Clinical Affairs must review the written recommendations and approve the temporary clinical privileges for the applicant.

(iii) **Locum Tenens.** Temporary privileges may be granted to qualified physicians providing services on a locum tenens basis if the applicant meets the qualifications for membership and his/her application has been verified. Such privileges shall lapse upon the expiration of such Physician's ability to be considered a locum tenens physician under Medicare rules.

(b) **Limitations.** In exercising temporary privileges, the practitioner will be monitored and observed by the Service Chief(s) to which he or she is assigned. Temporary privileges do not include staff membership or the prerogatives or rights of staff members, except the privileges of admitting and treating patients within the scope of the appointment; however, the person receiving a temporary appointment is subject to all obligations of staff members under these Bylaws. Temporary privileges may be suspended or terminated at any time by anyone entitled to summarily suspend a staff member's privileges. A person whose temporary privileges are terminated shall not be entitled to the procedural

rights set forth under Article VII. No person who has applied for privileges and staff membership may exercise temporary privileges contrary to the recommendations of the Credentials Committee or the Executive Committee made upon consideration of the application.

### **3.10 Emergency privileges.**

(a) In an emergency, a physician, dentist or podiatrist who is a member of the staff may do all that is possible within the scope of the person's license to save the patient's life or to save the patient from serious harm and in so doing may exercise clinical privileges not otherwise granted the member. The staff member will call for an appropriate consultation, unless the emergency is clearly within the scope of the member's clinical privileges.

(b) Emergency privileges will terminate upon the termination of the emergency or upon the arrival of a staff member whose privileges otherwise permit the member to treat the patient and who will become responsible for the patient, except that the emergency privileges may continue under the observation of the staff member until the patient's procedure is performed if the Chief Clinical Officer or Chief of Staff consents thereto.

(c) For the purpose of this section, an "emergency" is defined as a condition for which delay in administering treatment could result in serious or permanent harm to a patient.

**3.11 Disaster Privileges.** Disaster privileges may be granted for volunteer Licensed Practitioners who are not members of the Medical Staff when the Medical Center's Emergency Operations Plan has been activated. The Chief Executive Officer, EVP for Clinical Affairs, Chief Clinical Officer or highest ranking member of the administrative management available, or the Chief of Staff or highest ranking member of the Medical Staff available, may grant disaster privileges under the general process outlined. Granting of disaster privileges under these circumstances is discretionary with above stated authorized individuals based upon available information regarding the extent of the disaster, staffing capabilities, number and type of injuries anticipated. Specialty Specific Privileges may be granted to the volunteer Licensed Practitioner only after the Medical Center receives a valid government issued photo identification issued by a state or federal agency and a second verifying source as required by the Medical Staff.

Persons who are privileged under these circumstances will be appropriately identified by badge, which badge will specifically identify the Licensed Practitioner as one with disaster privileges and not a full member of the medical staff. The Licensed Practitioner will be assigned to a treatment area with another Licensed Practitioner, who is a member of the Medical Staff and of similar specialty, if at all possible, to work collaboratively with the Licensed Practitioner. The assigned member of the Medical Staff will provide oversight and monitoring using medical record review with respect to the Licensed Practitioner granted disaster privileges. Disaster privileges for the Licensed Practitioner will terminate when the emergency or disaster condition is cleared by the Medical Center through its Medical Center Emergency Operations Plan. The Medical Center makes a decision within 72 hours related to the continuation of the disaster privileges initially granted. Primary source verification of licensure will begin as soon as the immediate situation is under control and will be completed within 72 hours from the time the volunteer practitioner presents to the Medical Center, unless there are extraordinary circumstances. If the primary source verification cannot be completed within the 72-hour window, the reasons must be documented as a part of the Temporary Privileges for Care of Specific Patients process. Following the resolution of the immediate disaster situation, as determined by the Medical Center, the disaster privileges for the Licensed Practitioner will be verified using the process for Temporary Privileges for Care of Specific Patients.

**3.12 Other Health Professionals.** Licensed health care professionals other than physicians, dentists, podiatrists, or psychologists regardless of whether they are employees of the Medical Center (“Other Health Professionals”) will have the right to perform services in the Medical Center upon submission of their qualifications and approval by the Medical Staff and the Board. Notwithstanding the foregoing, Other Health Professionals who are also Allied Health Practitioners as defined in Article XVII, Section 17.1 will be subject to Article VIII. The Medical Staff and the Board will determine whether a specific class of other health professionals may perform services in the Medical Center.

**3.13 Staff Dues.** Medical Staff dues shall be as established by the Medical Executive Committee and may vary by category. Dues are payable no later than January 1 of each year unless determined otherwise by the Medical Executive Committee. Dues are nonrefundable and will not be prorated.

#### **ARTICLE IV CATEGORIES OF THE MEDICAL STAFF**

**4.1 The Medical Staff.** The Medical Staff will be divided into Active, Courtesy, Honorary, Contract Physician, Administrative, Membership Only, and Tele-Medicine Entity. Except for members of the honorary category who have no privileges, all staff members will meet the qualifications set forth in 3.4 and have the ability to provide continuous care to their patients admitted to the Medical Center. All members, except honorary members and AHPs must hold a continuous faculty appointment with the College of Medicine & Life Sciences. Should such faculty appointment not be renewed, be terminated or voluntarily withdrawn, the privileges of the member will also lapse and the member will not be entitled to a fair hearing or appeal under Article VII below. The member will instead have any rights afforded to such faculty member under applicable University policy.

**4.2 Honorary Medical Staff.** Honorary Medical Staff members will consist of physicians, dentists, podiatrists, and psychologists who, although not active at the Medical Center, have rendered distinguished service to the practice of medicine, dentistry, podiatry or psychology. Honorary staff members will not be required to attend staff meetings. They will be allowed to attend staff meetings but will not be allowed to vote, hold office, serve on any staff committee or admit or care for patients. Honorary members need not reside in the community.

**4.3 The Active Medical Staff.**

(a) **Qualifications.** The Active Medical Staff will consist of those physicians, dentists, podiatrists, and psychologists who hold a faculty appointment from The University of Toledo (upon the granting of privileges or shortly thereafter) and who regularly admit patients to the Medical Center, or otherwise are regularly involved in the care of patients admitted to the Medical Center, who provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the active Medical Staff, including, where appropriate, emergency service care and consultation services. Members of the active Medical Staff must: admit or provide consultation to at least twenty five (25) Medical Center admitted patients per year or see approximately five (5) patients per week, on average, in the Medical Center ambulatory care clinics.

(b) **Prerogatives.** Members of the active Medical Staff will be eligible to vote, to hold office and to serve on Medical Staff committees. Active staff members may admit patients to the Medical Center.

(c) **Responsibilities.** Each member of the active staff will:

(1) Assist in transacting all business functions and meeting all responsibilities of the

staff;

- (2) Be responsible for the continuous care and supervision of each patient in the Medical Center who has been admitted by the member or for whom the member is providing coverage;
- (3) Actively participate in quality management activities required of the staff, in observing first time appointees, and in discharging such other staff functions as may from time to time be required;
- (4) Attend such meetings of staff, clinical services, and committees as may be required by these Bylaws; and
- (5) Serve on the on-call roster, if asked.

(d) **Observation.** New staff members will be monitored and observed according to the FPPE and OPPE policies and procedures of the Medical Staff by the Chiefs of the Services or their representatives and the appropriate medical staff peer review committee(s) in exercising the clinical privileges granted to them. Monitoring and observation may be extended according to applicable policy.

**4.4 The Courtesy Medical Staff.** The courtesy Medical Staff will consist of physicians, dentists, podiatrists and psychologists qualified for staff membership but who only occasionally admit patients to the Medical Center or who act only as consultants. Courtesy Medical Staff members will not be eligible to vote or hold office in the Medical Staff organization. They will not be required to serve on committees but may serve on committees if they desire and are appointed, or attend staff or service meetings if they desire. Courtesy staff members may admit patients to the Medical Center. Admissions by courtesy staff members may be reviewed according to the FPPE or OPPE peer review Policies of the Medical Staff. Each member of the courtesy staff will be responsible for the continuous care and supervision of each patient in the Medical Center who has been admitted by the member or for whom the member is providing services.

Courtesy staff members will be monitored and observed according to the FPPE or OPPE policy applicable to them to exercise the clinical privileges granted to them. The courtesy Medical Staff must participate in emergency room and other specialty coverage programs if requested to do so by the Executive Committee.

#### **4.5 The Administrative Medical Staff.**

(a) **Qualifications.** The Administrative Medical Staff will consist of those physicians, dentists, podiatrists, and psychologists who hold a faculty appointment from The University of Toledo, who are employed on a full-time basis by the University to serve administrative functions for the Medical Center, and who assume all the functions and responsibilities of membership on the Administrative Medical Staff.

(b) **Prerogatives.** Members of the Administrative Medical Staff will be eligible to vote, to hold office and to serve on Medical Staff committees. Administrative staff members may have clinical privileges and admit patients to the Medical Center to the same degree and in the same manner as Courtesy Staff; however, they must qualify and become members of the Active Medical Staff, and perform all obligations of Active Medical Staff members, if they admit or provide consultation to twenty five (25) Medical Center admitted patients per year or more, or see five (5) patients per week or more, on average, in the Medical Center ambulatory care clinics.

(c) **Responsibilities.** Each member of the Administrative Medical Staff will:

- (1) Assist in transacting all business functions and meeting all responsibilities of the staff;
- (2) Administratively participate in quality management activities required of the staff, in observing first time appointees, and in discharging such other staff functions as may from time to time be required; and
- (3) Attend such meetings of staff, clinical services, and committees as may be required by these Bylaws.

**4.6 Contract physicians.** The contract physician Medical Staff consists of physicians who are not on any other staff category of the Medical Center but who serve patients pursuant to a contract with the Medical Center. Members of the contract physician staff will not be entitled to vote or hold office. Practitioners under contract will not be automatically entitled to appointment to the staff, a particular staff category, or particular privileges solely by virtue of the person's contract with the Medical Center, but will be required to apply and to be considered for staff membership and clinical privileges as any other practitioner. Similarly, unless otherwise provided by contract, termination of the person's contract by the Medical Center will not automatically result in a termination of the person's staff membership or clinical privileges. The Medical Center may provide in any practitioner's contract that the practitioner's status is contingent upon becoming and remaining a member of the active staff and that termination of the contract may include termination of all or a portion of the practitioner's clinical privileges.

#### **4.7 Membership Only Medical Staff.**

(a) Qualifications:

The Membership Only category consists of those physicians, dentists, oral surgeons, podiatrists, and psychologists who:

- (1) desire to be associated with, but who do not intend to establish a clinical practice at, this Medical Center;
- (2) have indicated or demonstrated a willingness to assume all the responsibilities of membership; and
- (3) desire to serve on the faculty of the University of Toledo.

(b) Guidelines:

The Membership Only Medical Staff is a membership-only category, with no clinical privileges being granted. The primary purpose of the Membership Only Medical Staff is to promote professional and educational opportunities, including medical education.

(c) Prerogatives and Responsibilities:

(a) Membership Only Medical Staff members:

- (1) may attend meetings of the Medical Staff and applicable service lines (without vote);
- (2) may not hold office;

- (3) may serve as a service line executive medical director, division, chief, medical director, or committee chair;
- (4) shall generally have no staff committee responsibilities, but may be invited to serve on a committee (with vote);
- (5) may attend educational activities sponsored by the Medical Staff and the Medical Center; and
- (6) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Medical Center.

**4.8 Telemedicine Medical Staff.** Telemedicine Staff shall consist of Licensed Practitioners that provide Telemedicine Services only. Telemedicine Medical Staff membership shall not be eligible to vote or hold office in the Medical Staff organization, shall not be required to serve on committees and may not admit patients to the Medical Center.

## **ARTICLE V APPOINTMENT, REAPPOINTMENT, CHANGES IN STAFF CATEGORY AND ADDITIONAL PRIVILEGES**

**5.1 General procedure.** Application to become a member of the Medical Staff will be made on the prescribed form to the appropriate Service Chief and will state the education, qualifications, and references of the applicant. The application form will include a statement that the applicant has received and read the Medical Staff Bylaws and that the applicant agrees to adhere to them.

(a) **Burden of applicant.** The applicant, whether for initial appointment or subsequent reappointment to the Medical Staff, will have the burden of submitting a complete application; producing adequate information for the proper evaluation of the applicant's competence, character and qualifications; and resolving any doubts about such qualifications. Each applicant for staff membership or privileges has the responsibility of proving that the applicant meets the qualifications for staff membership and privileges. Each member of the staff has the responsibility of proving that the member continues to meet the qualifications for staff membership and privileges.

(b) **National Practitioner Data Bank (NPDB).** The Credentials Committee will either:

- (1) Request from the NPDB information reported to the NPDB at the time a practitioner applies for a position on the staff or for clinical privileges at the Medical Center and at a minimum bi-annually, at the time of reappointment, or upon application for additional privileges for each practitioner who is on the staff or has clinical privileges at this Medical Center; or
- (2) Elect to have the NPDB continuously monitor all practitioners privileged, credentialed or monitored through the Medical Staff, including AHPs and notify the Credentials Committee or designee of any adverse licensure, privileging, Medicare/Medicaid exclusions, civil and criminal convictions and medical malpractice payments on such practitioners and confirm at the time of application or renewal, or in the



interim as necessary as determined by the Chair of the Credentials Committee, that all information received from the NPDB is provided to the Credentials Committee and considered.

**5.2 Application for initial appointment.** Each application for initial appointment to the staff will be made by submitting a properly completed and signed form prescribed by the Credentials Committee. It is the applicant's responsibility to provide the needed information. Incomplete applications will not be processed.

(a) **Information about applicant.** The application form will include:

(1) **Proof of Identity.** The applicant will provide to the Medical Staff Office for review a government issued photo ID (e.g. driver's license or passport);

(2) **Qualifications.** Detailed information concerning the applicant's qualifications, specifically including, without limitation, information concerning the qualifications and considerations specified in Sections 3.3, 3.4 and professional liability insurance required under Section 6.8(b);

(3) **References.** The name of at least two (2) persons who have worked with the applicant, have observed the applicant's professional performance, and can provide opinions concerning the applicant's clinical ability, professional judgment, ethical character and ability to work with others;

(4) **Professional affiliations and licenses.** (a) The applicant's past and present membership status or privileges at any other hospital or healthcare institution, (b) evidence of any specialty board certification, (c) evidence of the applicant's Drug Enforcement Agency registration, if applicable, and (d) evidence of a current license to practice medicine, osteopathic medicine, dentistry, podiatry, or psychology in Ohio;

(5) **Professional sanctions.** Information as to whether: (a) any membership or privileges at any other hospital or healthcare institution, (b) any specialty board certification, (c) any license to practice any profession in any jurisdiction, or d) any Drug Enforcement Agency registration, has ever been voluntarily or involuntarily relinquished, suspended, revoked, or denied or is subject to pending challenge or investigation and, if so, the particulars thereof;

(6) **Professional liability experience.** Information on the applicant's prior professional liability claims, including details about coverage, claims, suits and any payments or settlements made by or on behalf of the applicant or judgments against the applicant. This also includes names of present and past professional liability insurance carriers and further information regarding the above from these carriers; and

(7) **Peer Review Organization (PRO) sanctions.** Information about current and past PRO sanctions against the applicant and current PRO inquiries and sanction recommendations.

(b) **Agreements by applicant.** By signing and submitting the application, the applicant warrants the following:

(1) **Compliance with Medical Center and staff procedures.** The applicant's agreement that he or she has received and read the staff Bylaws and agrees to be bound by

the Bylaws and Policies of the staff and all policies and rules of the Medical Center for all matters relating to consideration of the application and, if membership on the staff and privileges are extended to and accepted by the applicant, for all matters relating to the applicant's staff membership and privileges;

(2) **Exhaust remedies.** The applicant's agreement to exhaust any administrative remedies and procedures afforded by the Bylaws and Policies of the staff and other remedies and procedures afforded by the Medical Center before resorting to other legal remedies;

(3) **Appear for interviews.** The applicant's agreement to appear for interviews concerning the application upon request;

(4) **Provide health information.** The applicant's agreement that information concerning the applicant's physical or mental health will be supplied upon request;

(5) **Continuous Care.** The applicant's agreement to provide continuous care and supervision to all patients within the Medical Center for whom he or she has responsibility;

(6) **Investigate background.** The applicant's agreement permitting Medical Center representatives and the staff to consult with others who have been associated with the applicant and who may have information concerning the applicant's qualifications and other considerations relating to membership on the staff and the enjoyment of privileges;

(7) **Authorization for others to provide information.** The applicant's authorization and request to all individuals and all hospitals, medical associations, licensing boards, PROs and all other organizations possibly having information relevant to the application or the applicant's continued qualifications for staff membership and privileges to supply such information to Medical Center representatives and the staff;

(8) **Inspection of Medical Center records.** The applicant's consent to the inspection by Medical Center representatives and the staff of all Medical Center records and documents which may be material to an evaluation of the applicant's qualifications and other considerations relating to membership on the staff and the enjoyment of privileges;

(9) **Release.** The applicant's release of all Medical Center employees, staff and representatives, members of the staff, The University of Toledo and the Board from any liability for any act performed in good faith in connection with evaluating the application and, if the applicant is granted staff membership or privileges, his or her continued qualifications therefor; and,

(10) **Release.** The applicant's release of all individuals, hospitals, and other organizations who provide to Medical Center representatives and staff members in good faith information, including otherwise privileged or confidential information, concerning the qualifications of the applicant and other considerations relating to the applicant's continued membership on the staff and enjoyment of privileges.

(c) **Signature of applicant.** Each application will be signed by the applicant.

### **5.3 Applications for reappointment, changes in category, or additional privileges.**

(a) **Reappointments.** A reappointment application for membership and privileges (as applicable) will be mailed or emailed to each staff member at least ninety (90) days before the expiration of the member's then current term of appointment. The staff member will be responsible for completing the reappointment application and for updating his or her professional information by supplying, in writing, current information concerning the member's qualifications for reappointment. The staff member will provide information for the preceding two (2) years regarding the information set forth below.

(b) **Changes in category or privileges.** Each application for change in category or status, or additional privileges will be in writing supported with information sufficient to add to the applicant's file information about the applicant's healthcare related activities other than as a member of the staff since the previous application and to support the requested change in category or additional privileges.

(c) **Automatic Change in Category.** Any member of the Medical Staff who has no patient activity at the Hospital for two (2) reappointment cycles will automatically cease to have clinical privileges and will be transferred to the appropriate Medical Staff category (Administrative Medical Staff or Membership Only Medical Staff). Any such automatic expiration of clinical privileges and transfer of membership status based on inactivity shall not be deemed to be an adverse action based on the member's competence or professional conduct, and shall not give rise to any notice and hearing rights under Article VII below.

### **5.4 Processing applications.**

(a) **Generally.** Each application for appointment to the staff and for privileges, for change in staff category or status, for additional privileges, or for reappointment will be processed in the manner set forth in this Section 5.4, with the possible exception of delegated credentialing for tele-medicine applications under Section 5.5 below.

(b) **Verification of information.** Each application will be delivered to the Central Verification Office, who will be responsible for collecting and verifying the references, licenses, and other qualifications noted on or submitted with the application. Medical Staff Services will be responsible for notifying the applicant of any unsuccessful efforts to collect or verify such information. The applicant will be given the opportunity to respond in writing to supply any additional materials in support of the application. The Credentials Committee Chair or designee will notify the applicant of the Credentials Committee's determination that the application has been unable to be evaluated and will not be processed because it was incomplete or unable to be verified. For an application not evaluated, the applicant will not be eligible to reapply for the staff category or privileges for a period of one year from the date of notice to the applicant, unless the Credentials Committee permits the applicant to reapply sooner. Any applicant whose application is incomplete or unable to be verified is not entitled to the notice and hearing rights set forth in Article VII.

(c) **Clinical Service action.** As soon as all information necessary to the application has been collected and verified, Medical Staff Services on behalf of the Credentials Committee will transmit the application and all supporting materials to the Chief of each Service in which the applicant seeks privileges. In addition, any staff member will have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns he or she may have about another applicant. Medical Staff Services, on behalf of the Credentials Committee, will maintain the original copies of all applications and supporting materials.

Upon receipt of an application, the Service Chief(s) in which clinical privileges are sought will review the application and supporting documentation and make recommendations concerning the application and, if appointment is recommended, staff category, service affiliations, privileges, and any special conditions which should be attached to the appointment. The recommendations together with the application and all materials reviewed will be transmitted to the Credentials Committee after the application is received and reviewed by the Service Chief. The Chief of Staff or designee will review the reappointment applications of all Service Chiefs and make a recommendation to the Credentials Committee regarding reappointment of membership and privileges. The Vice Chief of Staff shall review any reappointment for the Chief of Staff and make the recommendations to the Credentials Committee.

(d) **Credentials Committee action.** At its next regular meeting after receiving the recommendations of the Service Chief under Section 5.4(c), the Credentials Committee will review the application, the supporting documentation, the recommendations of the clinical services, and such other information available to it that may be relevant to the applicant's staff category, service affiliation, and privileges requested.

The recommendations, the application, and all material reviewed by the Credentials Committee will be transmitted to the Executive Committee to be considered at its next regularly scheduled meeting after the Credentials Committee completes its review of the application.

(e) **Executive Committee action.** The Executive Committee will consider the recommendations by the Credentials Committee on the application and other relevant information available to it and prepare a written report of its recommendations concerning the action which should be taken on the application.

The Executive Committee may defer considering and reporting on an application, but for no more than sixty (60) days. The Executive Committee will notify the Service Chief and the applicant of the deferral.

(f) **Processing the application after Executive Committee action.**

(1) **Favorable action.** If the Executive Committee recommends that the applicant be appointed to the staff and privileges granted (as applicable), and Section 5.4 (f)(2) below does not apply, the Chief of Staff will promptly forward the application, the reports of the Executive Committee, and all supporting documentation to the Board.

(2) **Adverse Action.** Processing of the application will be completed under Article VII whenever the Executive Committee recommends:

(i) Denial of all or part of the requested privileges; or

(ii) Additional requirements of consultation, supervision affecting privileges, or other limitations on privileges not already in place at the time the application was submitted.

No Adverse Action recommendation will be forwarded to the Board until after the practitioner has exercised or has been deemed to have waived his or her rights to a hearing as provided in Article VII of these Bylaws.

(g) **Action by the Board.** At its next regularly scheduled meeting after receiving a report by the Executive Committee under Section 5.4(f)(1), the Board will review and act upon the

recommendation(s).

(1) **Approval of recommendation(s).** If Section 5.4(f)(2) does not apply, the Board's approval of the action(s) of the Executive Committee will be deemed a granting of the privileges and rights as set forth in these bylaws.

(2) **Other action.** If the Board votes to take any action inconsistent with the Executive Committee's action, the matter will be referred to the Joint Conference Committee before any hearing that may otherwise be required is held. Processing of the matter must be completed under Article VII whenever the Board or the Joint Conference Committee votes to take any action listed in Section 5.4(f)(2) if a hearing concerning the privileges in question has not already been held or waived.

(h) **Reapplication after denial.** If the final action of the Board is a denial of the requested staff category or all or part of the requested privileges, the applicant will not be eligible to reapply for the staff category or privileges denied for a period of one year from the date of denial. Thereafter, if the applicant is not a member of the staff, the applicant may apply for the denied staff membership and privileges in the same manner as any other initial application for membership and privileges or, if the applicant is a member of the staff, as any other member of the staff would apply for change in staff category or additional privileges, but in either case will include in any application information which affirmatively demonstrates that the basis for the earlier denial of membership or privileges no longer exists.

**5.5 Tele-Medicine Applications.** The application submitted by a telemedicine applicant must contain the following:

(a) **License.** Evidence of a current license to practice medicine or osteopathic medicine in Ohio or a current telemedicine certificate issued pursuant to Ohio Revised Code §4731.296 or the corresponding provision of any successor law.

(b) **Telemedicine Entity.** Evidence that the applicant will furnish services through a telemedicine entity that has a valid, current written agreement with the Medical Center and meets the requirements of telemedicine as set forth by: (1) the Joint Commission; (2) the Healthcare Facilities Accreditation Program (HFAP) as authorized by the Centers for Medicare, and Medicaid Services (CMS); (3) the Medical Center, in that the Medical Center has approved the applicant to furnish services at the Medical Center under the agreement; and the distant-site either (i) is a Medicare participating hospital that is accredited by the Joint Commission and the agreement requires such hospital to meet the Medicare conditions of participation for the contracted services, including but not limited to Medicare requirements with regard to the telemedicine entity's physicians and other practitioners providing telemedicine services and applicable Joint Commission requirements, or (ii) is a Joint Commission accredited ambulatory care organization that furnishes the contracted services in a manner that permits the Medical Center to comply with Joint Commission requirements and the Medicare conditions of participation.

If the applicant is a telemedicine applicant, the licensure will be verified with the State Medical Board of Ohio and approval of the applicant described in 5.03(b) will be verified with the relevant telemedicine entity.

(c) **Disclosures.** A statement that the applicant has agreed to permit the Medical Center to send its internal review of the applicant's performance at the Medical Center to the Telemedicine Entity, including but not limited to information concerning adverse events that may have resulted from the

applicant's telemedicine services and all complaints received by the Medical Center about the applicant.

(d) **Processing.** Applications for tele-medicine will be processed in the same manner as applications for other categories of the Medical Staff membership, except in cases where the Medical Center has contracted with a Joint Commission accredited ambulatory care organization to provide credentialing services on behalf of Medical Center, to the extent permitted by the Joint Commission. This requires that if the Medical Center does not privilege and credential the practitioner pursuant to the process set forth for other categories of staff membership, it can either:

- (1) Obtain and use credentialing information from the distant site (the site where the practitioner has privileges) if the distant site is JC accredited, or
- (2) Use the credentialing and privileging decision from the distant site to make a final privileging decision if the following requirements are met:
  - (i) the distant site is a Joint Commission-accredited hospital or ambulatory care organization;
  - (ii) the practitioner is privileged at the distant site for the services to be provided at the Medical Center; and
  - (iii) the Medical Center performs and documents an internal review of the practitioner's performance of his/her privileges and sends the review to the distant site to allow it to assess the practitioner's quality of care, treatment and services for use in privileging and performance improvement, to include all adverse outcomes related to sentinel events as defined by JC that result from tele-medicine services provided, as well as complaints about the practitioner from patients, other practitioners or staff.

(e) **Credentialing.** The Medical Staff will determine through its established credentialing process the delineation of privileges to be granted to any member of the tele-medicine Medical Staff and retains responsibility for overseeing the quality and safety of services offered through tele-medicine. Any privileges granted through delegated credentialing will terminate automatically in the event of termination of the credentialing agreement by which such privileges arise or termination of the practitioner's affiliation with the credentialing entity.

## **ARTICLE VI SUSPENSION AND INVESTIGATION**

### **6.1 Initiation of Investigation.**

**A. Grounds.** A staff member may be investigated whenever any of the following is questioned:

- (a) the member's clinical competence or professional judgment;
- (b) the member's compliance with these Bylaws;
- (c) whether the member is able to perform the obligations of staff membership;
- (d) whether the member's conduct is disruptive to Medical Center operations so as to

potentially affect patient care adversely; or

(e) whether the member meets the qualifications and considerations for staff membership and privileges.

**B. Requests for investigation.** All requests for corrective action will be in writing, will be made to the Chief of Staff, and will be supported by reference to the specific activities or conduct which constitutes the grounds for the request. An investigation will be conducted if the Chief of Staff receives such a written request from the Executive Committee, the Chief Clinical Officer, the EVP for Clinical Affairs, or the Board. The Chief of Staff or Chief Clinical Officer alone may request an investigation and document the specific activities or conduct which constitute the grounds for the request. Any staff member, other than the Chief of Staff or Service Chief, may request an investigation in writing to the Chief of Staff or Chief Clinical Officer, and the Executive Committee will approve or disapprove the request at its meeting.

**C. Suspension upon investigation.** Either (i) the Board, (ii) the Chief Clinical Officer with the concurrence of either the Chief of Staff or the Service Chief affected, (iii) the Executive Committee, may suspend staff membership or restrict privileges for a period of no longer than fourteen (14) days during which an investigation is being conducted, unless a suspension is otherwise justified under Section 6.7 or a termination is justified under Section 6.9. The notice and hearing provisions of Article VII do not apply to a suspension of staff membership or restriction of privileges during the investigation period if the suspension is not beyond fourteen (14) days. Suspension of staff membership or restriction of privileges during an investigation will take effect immediately upon notification of the staff member concerned. The Chief of Staff and the Chief Clinical Officer will be notified as soon as possible of the suspension of staff membership or restriction of privileges during an investigation. If the suspension upon investigation is beyond fourteen (14) days, the practitioner is entitled to the rights set forth in 6.3(c) below.

## **6.2 Investigations.**

(a) **Notices.** The Board or the Executive Committee will provide the Chief Executive Officer a copy of any request for investigation within one (1) business day after receiving it. The Chief Executive Officer will notify the staff member of the investigation in writing, setting forth in writing the specific activities or conduct which constitute the grounds for the request and will provide a copy to the Chief Clinical Officer and EVP for Clinical Affairs. The EVP for Clinical Affairs will notify the Board.

(b) **Investigation committee.** As soon as possible after receiving a request for investigation, the Chief of Staff and Chief Clinical Officer will appoint a minimum of three (3) persons to investigate the matter and report upon the investigation (see the 14 day timeframe in Section 6.1(c) above and 6.2(c) below). Consideration should be given to appointing persons with experience in the particular specialty involved, giving careful consideration to any potential conflicts.

(c) **Right of Affected Person to Participate in Investigation: Settlement.** Anyone investigated may make an oral or written presentation to the Ad Hoc Investigating Committee and the Executive Committee. The committees may invite, but not require, the staff member to participate in any meeting. The member may be accompanied by an advisor, but the advisor shall not be an attorney and shall not participate in any meeting, except to advise the affected staff member. Affected staff members and investigating committees shall attempt to devise a solution to any problems satisfactory to the affected person and Medical Center.

(d) **Investigation report.** The investigation report will be in writing and will recommend specific actions, state the reasons for the specific actions and specifically refer to the information that was considered. All relevant material reviewed during the investigation and the report will be forwarded to the Chief of Staff no later than thirty (30) days after the request for investigation under Section 6.1(b).

### **6.3 Action by the Executive Committee.**

(a) **Scope of action.** The Executive Committee will act within thirty (30) days after the Chief of Staff receives the investigation report. The Executive Committee may adopt, reject, or modify the action recommended. The action may include, but is not limited to:

- (1) Recommending discontinuing the investigation;
- (2) Recommending training or other remediation in lieu of discipline or to avoid further discipline;
- (3) Recommending a warning or a letter of reprimand;
- (4) Recommending or summarily imposing requirements of consultation, supervision, or other limitations on privileges;
- (5) Recommending or summarily imposing reduction or suspension of privileges or staff membership; and
- (6) Deferring final decision for further investigation not more than twenty (20) days.

(b) **Reports of the Executive Committee.** The Executive Committee will make a written report of its action. The report will specify the action taken and the reasons for taking the action supported by specific references to the information that the Committee reviewed. Members of the Executive Committee who disagree with the report may make minority reports in the same form as the majority report. The reports of the Executive Committee and the supporting information will be delivered to the EVP for Clinical Affairs. The EVP for Clinical Affairs share the findings within the reports with the Board.

(c) **Right to a hearing.** A practitioner has the right to a hearing if:

- (1) the member's staff membership or privileges have been summarily suspended and the decision to suspend is upheld after review under Section 6.7(e);
- (2) the Executive Committee has recommended an Adverse Action; or
- (3) the Board decides to institute an Adverse Action either in line with or contrary to a favorable recommendation by the Executive Committee under circumstances where no right to a hearing existed, or on the Board's own initiative without benefit of a prior recommendation by the Executive Committee.

An Adverse Action means the recommendation or action to institute the following:

- (1) Requirements of consultation, supervision, or other limitation on privileges that affect the practitioner's ability to take medical action (e.g. requirement that a practitioner notify the Service Chief after conducting a particular procedure does not affect the



practitioner's ability to do the procedure, but a requirement that the Service Chief approve the procedure in advance does affect the practitioner's ability to take action);

- (2) Denial, reduction, suspension, or termination of privileges or staff membership; and
- (3) Denial of requested changes in staff category.

Notwithstanding the foregoing, an Adverse Action does not include (and a practitioner will not be entitled to a hearing for) automatic termination under Section 6.9; temporary suspension under Section 6.8; automatic suspension or termination under Section 6.8(c); suspension upon investigation under Section 6.1 no longer than fourteen (14) days in order to determine whether further action needs to be taken; or the issuance of a warning, a letter of admonition, or a letter of reprimand or the imposition of a retrospective review or other conditions not affecting privileges. Any staff member whose membership and privileges have been automatically terminated under Section 6.8(b)(iii)(d) or Section 6.9 does not have the rights to notice and hearing under Article VII.

(d) **Notice.** The affected staff member will receive prompt notice of the Executive Committee's action and, if applicable, the right to a hearing.

**6.4 Action by the Board.** The Board will review and act upon the Executive Committee's action. The Board's action will not be final until any required hearing is concluded.

(a) **Approval of Executive Committee action.** If the Board approves the action of the Executive Committee, the approval of the Board will be noted and the Chief of Staff will notify the applicant in writing of the action taken.

(b) **Other action.** If the Board votes to take any action inconsistent with the Executive Committee's action, the matter will be referred to the Joint Conference Committee before any hearing that may otherwise be required is held. If the affected practitioner has not already been afforded the rights under Article VII or waived those rights, processing of the matter must be completed under Article VII whenever the Board votes to take any of the actions described in Section 6.3(c).

**6.5 Patients of suspended staff member.** The Chief of Staff or the Chief(s) of Service(s) concerned will have the authority and responsibility to provide for alternative medical coverage for the patients of the suspended staff member remaining in the Medical Center at the time of such suspension.

**6.6 Suspension enforcement.** It will be the duty of the Chief of Staff, with the assistance of the Chief Clinical Officer to enforce all suspensions or restrictions on staff membership or privileges.

**6.7 Summary suspension.**

(a) **Grounds.** All or part of a staff member's privileges may be summarily suspended whenever:

- (1) The failure to take such action may result in an imminent danger to the health or safety of any individual; or
- (2) The member exercises privileges outside those specifically granted to the member or permitted by law.

(b) **Who may impose.** The Chief Executive Officer, the Chief of Staff, Chief Clinical

Officer [or a Service Chief only with concurrence of the Chief of Staff or Chief Clinical Officer], may impose summary suspension.

(c) **Notices.** The Chief of Staff and Chief Clinical Officer, or Chief Executive Officer will be notified of the summary suspension as soon as possible.

(d) **When effective.** Summary suspensions will be effective immediately upon notification to the affected staff member by any means and will not be delayed pending a hearing and will be followed with notification being hand delivered or mailed by certified mail, return receipt requested, to the affected practitioner.

(e) **Review by Executive Committee and notice to Practitioner.** The Executive Committee will, as soon as it may be practicable, but no later than seven (7) business days after the decision to summarily suspend, meet in person, by phone or by an internet web-based meeting to review the basis for the summary suspension and make its recommendation to the Board. If it elects to continue to summary suspension, a notice of same will be hand-delivered or mailed by certified mail, return receipt requested, to the affected practitioner. The matter will then be subject to Article VII.

## **6.8. Automatic Suspension.**

(a) **Failure to complete patient records.** A practitioner's privileges to admit patients and to consult with respect to patients admitted by another practitioner, and a member's voting and office-holding prerogatives may be temporarily suspended for failure to maintain and complete medical records in accordance with the Rules and Regulations of the Medical Staff. The person shall first be notified of the impending suspension and shall be given an opportunity to correct any deficiencies. The suspension shall terminate when the records have been completed, as determined and reported to the Chief of Staff, Service Chief, EVP for Clinical Affairs, and the Chief Executive Officer. Additional disciplinary measures may be imposed for repeated violations of these requirements. The Medical Center may also impose fines for such conduct. A person whose privileges have been temporarily suspended for failure to complete medical records is not entitled to the rights under Article VII.

### **(b) Failure to maintain insurance.**

(i) **Required Coverage.** All staff members, other professional staff and AHPs are required at all times to maintain professional liability insurance in the amount of one million dollars (\$1,000,000) per occurrence, three million dollars (\$3,000,000) in the aggregate, covering the acts or omissions of a member or AHP from an insurer duly licensed or approved to sell professional liability insurance or under a self-insured program that is actuarially reviewed and acceptable to the Credentials Committee ("Required Coverage").

(ii) **Failure to Maintain Required Coverage.** A member's privileges will be temporarily suspended for failure to maintain the Required Coverage. All other professional staff or AHPs will be prohibited from providing services within the Medical Center upon failure to maintain the Required Coverage.

(iii) **Member Requirements.** If a staff member fails, prior to the expiration of his or her current insurance policy, either to (i) provide documentation of the Required Coverage, or (ii) to certify in writing that the requisite insurance coverage has been obtained and the documentation requested and received from the appropriate company, then the member's privileges will be temporarily suspended. A member certifying in writing that

the requisite insurance coverage has been obtained and documentation received will be given up to the date of expiration of his or her current insurance policy to provide to the Credentials Verification Office evidence of the insurance coverage. When evidence of the requisite insurance coverage is provided up to the date of expiration of the member's current insurance policy, no temporary suspension for failure to maintain insurance will occur.

- a) The Chief of Staff or his or her designee will notify the affected staff member of a temporary suspension by certified mail, return receipt requested.
- b) The temporary suspension will terminate when Credentials Verification Office receives sufficient documentation that the Required Coverage has been obtained covering the entire period of time in which the insurance lapsed and going forward. A person whose privileges have been temporarily suspended for failure to obtain professional liability insurance is not entitled to the rights under Article VII.
- c) Staff membership and privileges will be automatically terminated for members who have failed to provide documentation of professional liability coverage in accordance with the requirements set forth by these Bylaws to the Medical Staff Services office within thirty (30) days after temporary suspension for failure to obtain insurance.
- d) Automatic termination will be imposed in the manner provided for summary suspension except that a person whose membership or privileges have been automatically terminated under this section is not entitled to a hearing under Article VII.

(c) **Failure to Pay Staff Dues.** Unless excused by the Medical Executive Committee for good cause, failure to render Medical Staff dues payment within 60 days of the due date may result, *after special notice of the delinquency*, in the automatic suspension of Medical Staff appointment (including all prerogatives) and clinical privileges until such time as the delinquency is remedied. If dues have not been paid within 90 days of the due date, the individual shall be deemed to have voluntarily resigned his or her Medical Staff appointment.

**6.9 Administrative Suspension.** The privileges of any Faculty Member who is suspended pursuant to the Faculty Rules and Regulations shall be automatically suspended during the duration of such Faculty suspension. Such suspension shall be considered administrative in nature and shall not entitle the affected practitioner to a hearing under Article VII.

#### **6.10 Automatic Termination.**

(a) **Grounds.** Staff membership and privileges will be automatically terminated: (1) for members whose licensure to practice in the State of Ohio is revoked or suspended; or (2) for members who hold a personal DEA registration with clinical privileges to prescribe controlled substances and whose DEA registration is revoked or suspended.

(b) **Procedure.** Automatic termination will be imposed in the manner provided for summary suspension except that a person whose membership or privileges have been automatically suspended is not entitled to a hearing under Article VII.

**6.11 Care of practitioner's patients.** Immediately upon the imposition of an automatic termination, the Chief of Staff or the responsible Chief(s) of Service(s) will have the authority and responsibility to direct alternative medical coverage for the patients of the terminated practitioner still in the Medical Center at the time of such termination. The wishes of the patients will be considered in the selection of such alternative practitioner.

(a) **Regaining terminated membership and privileges.** A practitioner whose staff membership and privileges were terminated under Section 6.10(a) due to a nonprofessional performance issue (e.g. failure to submit evidence of meeting continuing medical education requirements, which continuing medical education requirements were met.), may reapply for staff membership and privileges when the deficiency under Section 6.10(a) is rectified. The Credentials Committee will forward all reapplications for applicants whose staff membership and privileges were terminated under Section 6.10(a), directly to the Executive Committee, who will review the application, determine whether the termination was due to a nonprofessional performance issue, and make a recommendation to the Board.

### **6.12 Medical Staff Members' Rights before Executive Committee**

(a) Each Active member of the Medical Staff has the right to an audience with the Executive Committee for the limited purposes set forth in this Section 6.12. In the event an Active member is unable to resolve a difficulty working with his/her respective Service Chief, that member may, upon presentation of a written notice, meet with the Executive Committee to discuss the issue.

(b) Any Active member of the Medical Staff has the right to initiate a recall election of an Officer. A petition for such recall must be presented, signed by at least twenty five percent (25%) of the members of the Active Staff. Upon presentation of such valid petition, the Executive Committee will schedule a special general staff meeting for purposes of discussing the issue and, if appropriate, entertain a no-confidence vote.

(c) Any Active member may initiate the scheduling of a general staff meeting. Upon presentation of a petition signed by twenty five percent (25%) of the members of the Active Staff, the Executive Committee will schedule a general staff meeting for the specific purpose addressed by the member(s). No business other than that in the petition may be transacted at such a meeting.

(d) Any Active member may raise a challenge to any rule or policy established by the Executive Committee. In the event that a rule, regulation or policy is felt to be inappropriate, any Active member may submit a petition signed by twenty five percent (25%) of the members of the Active Staff. When such petition has been received by the Executive Committee, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation, or policy; or (2) schedule a meeting with the petitioners to discuss the issue.

This section 6.12 pertains only to these Sections (a) through (d) above and does not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual "credentialing" actions, summary suspension or any Adverse Action as defined in Section 6.3(c) to which a member is entitled to a hearing or appellate review. Such matters are handled as set forth in Article VII below.

## **ARTICLE VII HEARING AND APPELLATE REVIEW PROCEDURE**

### **7.1 Purposes of Article VII: Waivers and Agreements by Affected Person.**

(a) **Purposes.** The primary purpose of this Article VII is to ensure that anyone who is

entitled to a hearing gets a fair hearing by providing the following basic rights:

- (1) The right to a notice of an action or proposed action;
- (2) The right to be heard before an impartial hearing officer, arbitrator or hearing panel that permits the practitioner to hear the evidence presented against him or her and permits the practitioner to present evidence;
- (3) The right to a decision based upon the record of the hearing.

The secondary purpose of this Article is to protect those involved in the peer review process by taking advantage of the immunity provisions of the Federal Health Care Quality Improvement Act of 1986. So long as the basic rights of Article VII as listed above are afforded to the practitioner, the detailed requirements of this Article are not intended for any other purpose and the practitioner entitled to a hearing has no right to insist on strict compliance with the detailed requirements.

(b) **Exclusive Remedy.** This Article provides the only means to resolve issues arising out of matters entitling a person to a hearing under this Article. No person who applies for or accepts privileges and staff membership may commence court proceedings concerning action that may be heard under this Article unless the person completes the hearing and appellate review procedures afforded by this Article.

(c) **Procedure.** Objections to matters occurring before a hearing must be made to the Chief of Staff or Chief Clinical Officer. Objections to matters occurring during and after a hearing must be made to the person presiding over the hearing.

(d) **Voluntary Waiver of Notice or Hearing.** Any staff member or applicant for membership or privileges may voluntarily waive the member's or applicant's rights under this Article.

(e) **Waivers by Failure to Proceed under Article VII.** Any person entitled to a hearing or appellate review under this Article who fails to request a hearing or appellate review or to appear personally at a hearing or appellate review without good cause:

- (1) Waives any right to any hearing and to any appellate review;
- (2) Waives any right to assert in any court action the matters that could have been heard or presented;
- (3) Accepts any action by the Executive Committee and any action by the Board.

(f) **Waivers by Failure to Object.** All objections based on a failure to comply with this Article must be made in writing as soon as possible so that any errors that could affect the outcome of the proceedings may be corrected. Anyone who fails to make a timely objection based on a failure to comply with this Article waives the objection and will not assert the objection in any subsequent proceedings under this Article or in any court action.

(g) **No contract.** Nothing in these Bylaws is intended or will be construed to create contract rights in the practitioner or constitute waiver of or otherwise make ineffective any immunity from suit under federal or state law.

## 7.2 Right to Hearing and to Appellate Review.

(a) **Right to hearing.** Practitioner will be entitled to request a hearing for the reasons set forth in Section 6.3(c). If, after this hearing, the Executive Committee of the Medical Staff or Board recommendation, whichever is applicable, is still adverse to the practitioner then the practitioner will be entitled to request a review as set forth in Section 7.6 before the Board renders a final decision.

(b) **Notice of right to a hearing.** All hearings will be in accordance with the procedural safeguards set forth in this Article VII. Each practitioner who is entitled to a hearing as set forth in this Article will be given a notice which explains:

(1) The summary suspension or Adverse Action that gives the practitioner the right to a hearing and the reasons for the Adverse Action;

(2) The practitioner's right to request a hearing pursuant to Article VII of these Bylaws if he or she does so in writing pursuant to Section 7.1(b);

(3) A deadline of thirty (30) days following the date of receipt of the notice of action or recommendation within which to request a hearing in writing;

(4) That failure to request a hearing in writing within thirty (30) days following the receipt of notice will constitute a waiver of his or her right to same; and

(5) That a hearing is requested on a timely basis under Section 7.2(b)(3), the hearing will be held as determined by the Chief of Staff in consultation with the Executive Committee of the Medical Staff:

(i) before an arbitrator mutually acceptable to the practitioner and the Chief of Staff in consultation with the Executive Committee of the Medical Staff; or

(ii) before a hearing officer who is appointed by the Chief of Staff in consultation with the Executive Committee of the Medical Staff and who is not in direct economic competition with the practitioner involved.

(c) **Failure to appear.** The right to the hearing may be forfeited if the practitioner fails, without good cause, to appear at a scheduled hearing.

(d) **Rights in the hearing.** In the hearing, the practitioner involved has the right to:

(1) Representation by an attorney or other person of the practitioner's choice;

(2) Have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;

(3) Call, examine, and cross-examine witnesses;

(4) Present evidence determined to be relevant by the hearing officer or arbitrator regardless of its admissibility in a court of law; and

(5) Submit a written statement at the close of the hearing.

- (e) **Rights after the hearing.** Upon completion of the hearing, the practitioner has the right to:
  - (1) Receive the written recommendation of the arbitrator or hearing officer, including a statement of the basis for the recommendations; and
  - (2) Receive a written decision of the Board including a statement of the basis for the decision.

### **7.3 Request for Hearing; Waiver.**

(a) The Chief of Staff will be responsible for giving written notice by certified mail, return receipt requested, to any practitioner or applicant who is entitled to request a hearing. Such written notice will be in accordance with Section 7.2(b).

(b) Within thirty (30) calendar days after receipt of such notice, the applicant or practitioner may, by written notice delivered to the Chief of Staff by certified mail, return receipt requested, request a hearing. The failure of an applicant or practitioner to request a hearing to which he or she is entitled by these Bylaws within the time and in the manner herein provided will be deemed a waiver of his or her right to such a hearing and to any appellate review to which he or she may otherwise have been entitled on the matter.

(c) When the hearing related to an adverse recommendation of the Executive Committee of the Medical Staff is not requested within the designated time, the recommended action will thereupon become and remain effective against the practitioner or applicant pending the Board' decision on the matter. The Chief of Staff will promptly notify the affected practitioner or applicant of his or her status by certified mail, return receipt requested, that the decision has become effective.

### **7.4 Notice of Hearing.**

(a) Within ten (10) days after receipt of a request for hearing from a practitioner entitled to the same, the Chief of Staff will schedule a hearing and notify the practitioner of the time, place and date by hand delivery or certified mail, return receipt requested. The hearing date will be as soon as possible, but not less than thirty (30) days after the date of the notice of hearing under Section 7.1(b), unless the Chief of Staff and practitioner affected agree to an earlier time.

- (b) Notice of hearing. The notice of hearing will state in concise language:
  - (1) The acts or omissions with which the practitioner is charged;
  - (2) A list of specific or representative clinical records being questioned, if any;
  - (3) A list of witnesses, if any, expected to testify on behalf of the party whose action resulted in the affected practitioner's request for a hearing;
  - (4) The time, place and date of the hearing;
  - (5) That the practitioner should review the Medical Staff Bylaws, a copy of which will be provided to practitioner by the Medical Center, to determine the rights and procedures to which he or she is entitled, if any.

## 7.5 Composition of Hearing Committee.

When a hearing related to a summary suspension or a recommendation for an Adverse Action as defined in Section 6.3(c) above, of the Executive Committee or the Board is required, such hearing will be conducted as determined by the Chief of Staff in consultation with the Executive Committee:

- (a) Before an arbitrator mutually acceptable to the practitioner and the Chief of Staff and Chief Clinical Officer in consultation with the Executive Committee; or
- (b) Before a hearing officer who is appointed by the Chief of Staff and Chief Clinical Officer in consultation with the Executive Committee and who is not in direct economic competition with the practitioner involved.

## 7.6 Conduct of Hearing.

(a) **General.** The hearing officer shall decide each issue forming the basis for the Adverse Action and may affirm or reject all or part of the actin giving rise to the hearing or make other recommendations.

(b) **Evidence.** The hearing will be closed and informal. The rules of evidence for judicial procedure need not be followed. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs will be considered, regardless of the existence of any common law or statutory law which might make improper the admission of such evidence over objection in civil or criminal action. The arbitrator or the hearing officer may consider generally accepted technical or scientific matters, facts that may be judicially noticed by the courts of Ohio, pertinent material contained on file in the Medical Center, and information considered in connection with applications for appointment and reappointment to the staff and privileges.

(c) **Presiding officer.** The arbitrator or the hearing officer will preside over the hearing to determine the order or procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, to maintain decorum, and to rule on all questions of law, procedure, and evidence.

(d) **Right to representation.** The affected practitioner has the right to representation by an attorney or other person of his or her choice in the hearing. The Executive Committee and the Board has the right to representation by an attorney in the hearing and on appeal.

(e) **Record of hearing.** A record of the hearing will be kept that is of sufficient accuracy to assure that an informed valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing officer or arbitrator will select the method to be used, such as an audio tape recording, court reporter or detailed transcription. The affected practitioner has the right to obtain a copy of the proceedings upon payment of any reasonable charges associated with the preparation thereof.

(f) **Failure of Practitioner to appear.** No hearing will be conducted without the personal appearance of the practitioner for whom the hearing has been scheduled unless he or she waives such appearance or fails without good cause to appear for the hearing. A practitioner who fails without good cause to appear and proceed at such hearing will be deemed to have waived his or her rights in the same manner as provided in Section 7.2(b) and to have voluntarily accepted the adverse recommendation or decision involved, and the same will thereupon become and remain in effect as provided in Section 7.2(c).

(g) **Postponement.** Postponement of hearings beyond the time set forth in these Bylaws will be made only with the approval of the hearing officer or arbitrator. Granting of such postponement will



only be for good cause and in the sole discretion of the hearing officer or arbitrator.

(h) **Burden of proof.** The practitioner has the burden of proof by the greater weight of the evidence on all matters.

(i) **Rights of parties.** Having requested the hearing, if the practitioner does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

(j) **Recesses and adjournment.** The hearing officer or arbitrator may, without special notice, 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 oral and written information, the hearing will be closed. The hearing officer or arbitrator may thereupon at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

(l) **Report of the hearing.** Within five (5) days after final adjournment of the hearing, the hearing officer or arbitrator will make a written report of its findings and recommendations, specifying the basis for its decision, and will forward the same together with the hearing record and all other documentation to the Executive Committee of the Medical Staff or the Board, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee of the Medical Staff or decision of the Board. A copy of the report will be sent to the Chief Clinical Officer. No later than [thirty-five (35)] days after receipt of the report and recommendations of the hearing officer or arbitrator, the Executive Committee will render a decision affirming, modifying or rejecting its original recommendation including a statement of the basis for the decision. The decision will be forwarded to the Board for final action, and then to the Chief of Staff.

(m) **Right to appellate review.** The Chief of Staff will send a copy of the written recommendation of the hearing officer or arbitrator including a statement of the basis for the recommendations and the written decision of the Executive Committee or the Board (whichever is applicable), including a statement of the basis for the decision, to the practitioner.

If the result of the Executive Committee of the Medical Staff continues to be adverse to the practitioner, the notice by the Chief of Staff will inform the practitioner of his or her right to request an appellate review by the Board as provided in Section 7.7.

## **7.7 Appellate Review.**

(a) **Right of appeal.** If, after reviewing the report of the hearing officer or arbitrator the decision of the Executive Committee is adverse to the practitioner, the practitioner will have the right to appeal the decision to the appellate body (defined in subsection (e), below). The practitioner will give the Chief of Staff a written notice of his or her desire to exercise his or her right of appeal within ten (10) days from the practitioner's receipt of the Chief of Staff's written notice informing the practitioner of the decision of the Executive Committee. The appellate review will be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

(b) **Waiver of appeal.** If such appellate review is not requested within ten (10) days, the affected practitioner will be deemed to have waived his or her right to appeal and to accept such adverse recommendation or decision and the same will become effective immediately pending action by the Board.

(c) **Notice of appeal.** Within ten (10) days after receipt of such notice of request for appellate review, the Chief of Staff will schedule a date for such review including a time and place for oral argument if such has been requested. The Chief of Staff will notify the practitioner by written notice sent by certified mail, return receipt requested.

When the practitioner requesting the review is under a summary suspension which is then in effect, the appellate review will be scheduled as soon as the arrangements for it may practicably be made, but not more than ten (10) days from the date of receipt of such notice. For all other reviews, the appellate review will be as soon as practicable.

(d) **Written statements.** The affected practitioner will have access to the report of the findings of the hearing officer, or arbitrator and the record of the hearing officer or arbitrator.

Copies of the record are available to the practitioner upon payment of reasonable charges associated with the preparation thereof. He or she will have ten (10) days to submit a written statement on his or her behalf, stating those factual and procedural matters with which he or she disagrees, and his or her reasons for such disagreement will be specified.

This written statement may cover any matter raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement will be submitted to the appellate body (as set forth in subsection (e) below) through the Chief of Staff by hand delivery or certified mail, return receipt requested, at least ten (10) days prior to the scheduled date for the appellate review. A responsive statement may also be submitted by the Executive Committee of the Medical Staff and, if submitted, the Chief of Staff will provide a copy thereof to the practitioner at least five (5) days prior to the date of such appellate review by personal delivery or certified mail, return receipt requested.

If such report is received within five (5) days of the hearing date, the practitioner may request a continuance of the hearing date until he or she will have had five (5) days to review such report.

(e) **Conduct of appeal.** The appellate review will be conducted by the Board or by a duly appointed Appellate Review Committee of the Board of not less than five (5) persons and one (1) Board member. Any appeal proceedings will be conducted before a majority of the appellate body. If oral argument is requested as part of the review procedure, the practitioner will be permitted to speak against the adverse recommendation or decision, and will answer questions put to him or her by any member of the appellate review body. In such case, the Executive Committee of the Medical Staff will also be represented by an individual who will be permitted to speak in favor of the adverse recommendation or decision and who will answer questions put to him or her by any member of the appellate review body.

(f) **No new matters.** The appeal proceeding is not to be a complete rehearing of all matters presented before the panel, hearing officer or arbitrator. New facts or information not presented to the panel, hearing officer or arbitrator should not be considered by the appellate body in an appeal proceeding except under unusual circumstances. The appellate body has complete discretion to consider or reject such new matters. The appellate body's decision must be based solely on information either in the record or presented at the appeal proceeding.

(g) **Recommendation of appeal committee.** If the appellate review is conducted by an Appellate Review Committee of the Board, such Committee will, within five (5) days after the adjourned date of the appellate review, either make a written report recommending that the Board affirm, modify or reverse its prior decision, or refer the matter back to the hearing officer or arbitrator for further review and recommendation within ten (10) days.

Within five (5) days after receipt of such recommendation after referral, the Committee will make its recommendation to the Board as above provided.

(h) **Conclusion of appellate review.** The appellate review will not be deemed to be concluded until all of the procedural steps provided in Section 7.7 have been completed or waived.

### **7.8 Final Decision by Board.**

(a) At the next meeting of the Board, in Executive Session, the Board will make its decision in the matter and will send notice through the Chief of Staff, to the Executive Committee and to the practitioner by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee's last recommendation in the matter, the Board's decision will not be subject to further hearing or appellate review. If the Board's decision is to modify or reverse the Executive Committee's decision, the Board will refer the matter to the Joint Conference Committee for further review and recommendation within ten (10) days, and will include in such notice a statement that the decision is tentative and that the Board will consider the Joint Conference Committee's recommendation. At its next meeting after receipt of the Joint Conference Committee's recommendation, the Board will make its decision. If the Board's decision is to deny all Medical Staff privileges, then the Board's decision will be final. The Chief of Staff will send the written decision of the Board, including a statement of the basis for the decision to the affected practitioner by certified mail, return receipt requested.

(b) Notwithstanding any other provision of these Bylaws, no practitioner will be entitled as a right to more than one hearing and appellate review on any matter which will have been the subject of action by the Executive Committee of the Medical Staff, or by the Board, or by a duly authorized committee of the Board, with the exception of a second hearing based solely on whether the practitioner has the mental and physical health status to safely and competently perform the clinical privileges.

## **ARTICLE VIII ALLIED HEALTH PROFESSIONALS AND RESIDENTS**

**8.1 General provisions.** Allied Health Professionals (AHPs) are not members of the Medical Staff. They have only the rights and privileges as specifically indicated in these Bylaws. An AHP will have the right to perform services expressly requested by the AHP and expressly granted by the Board. The right to perform services exercised by each AHP is subject to the conditions attached to the AHP's grant of the right to perform services, the Bylaws and the Medical Staff Policies, policies of the Medical Center or The University of Toledo and the law.

**8.2 Qualifications.** AHPs must meet the same qualifications as are required of Medical Staff members, except that AHPs will be required to have the licenses, training, valid standard care arrangement, or utilization plan and supervision agreement, as applicable, with a physician member of the Medical Staff appropriate to their professions and any qualifications established by the Medical Center for the applicant's profession. The standard care arrangement or utilization plan and supervision agreement will contain all information required by law, including a delineation of the scope of practice for the AHP. AHPs in the same profession will be judged by the same qualification standards, whether they are employees of the Medical Center, employees of a Medical Staff member, or otherwise.

**8.3 Application procedure.** AHPs will be assigned to the clinical Services appropriate to their professional training. An application of an AHP to perform specified services will be submitted and processed in the same manner that the applications for Medical Staff membership and clinical privileges are processed as set forth in Article V, Sections 5.1 through 5.4. Suspension or termination of an AHP will occur as set forth in this Article VIII. An AHP will be entitled to the notice and hearing rights set

forth in this Article VIII.

**8.4 Prerogatives.** The prerogatives of an AHP will be to:

(a) Provide specified patient care services under the supervision or direction of a Physician member of the Medical Staff (except as otherwise expressly provided by resolution of the Executive Committee and approved by the Board) and

(b) Perform functions only to the extent established by the Medical Staff, but not beyond the scope of the AHPs license, certificate or other legal credential;

(c) As required, serve on committees, attend meetings, and participate in Medical Center education programs.

**8.5 Responsibilities.** Each AHP will

(a) Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Medical Center for whom he or she is providing services, or arrange a suitable alternative for such care and supervision. When appropriate, arrangements for alternate coverage should be made by or through the physician member of the Medical Staff who has ultimate responsibility for the patient's medical care.

(b) Participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the Staff, in supervising initial appointees of his or her same profession during the observation period, and in discharging such other staff functions as may be required from time to time.

**8.6 Suspension and termination of AHPs.**

(a) **Grounds.** All or part of an AHPs rights to perform services in the Medical Center may be summarily suspended or terminated whenever:

(i) The conduct of the AHP exposes, has exposed, or may expose any person present in the Medical Center to the substantial likelihood of loss of life, injury, or damage to health;

(ii) The conduct of the AHP is in willful disregard of the Medical Staff Bylaws, Policies or Medical Center or The University of Toledo rules, regulations or policies;

(iii) The AHP performs services outside those specifically granted to the AHP or the AHP is permitted to exercise by law;

(iv) The AHP's competence or professional judgment is questioned;

(v) The AHP's ability to perform the obligations of AHP membership is questioned;

(vi) The AHP's conduct is disruptive to Medical Center operations;

(vii) The AHP fails to maintain the Required Coverage as set forth in 6.8(b)(i) above;  
or

(viii) The AHP fails to meet any of the qualifications required of the AHP under law, including, but not limited to, failure to maintain a valid standard care arrangement, utilization plan, supervision agreement, or other appropriate supervision arrangement, as applicable, with a physician member of the Medical Staff.

(b) **Who may impose.** The Board, the Medical Staff through the Executive Committee, the Chief Executive Officer, the Chief Clinical Officer or EVP for Clinical Affairs of the Medical Center may suspend or terminate all or part of an AHP's rights to perform services in the Medical Center.

(c) **When effective.** Suspension or termination of all or part of an AHP's rights to perform services in the Medical Center will be effective immediately upon communication thereof by any means to the person whose right to perform services have been suspended or two (2) calendar days after notice thereof has been sent to the AHP by certified mail return receipt requested.

(d) **Automatic termination.**

(i) **Grounds.** An AHP's rights to perform services in the Medical Center will be automatically terminated whenever the AHP's authority to engage in the member's profession in the State of Ohio is revoked or suspended or if AHP fails to maintain the Required Coverage as set forth in Section 6.8(b)(i).

(ii) **Procedure.** When the grounds for it exist, automatic termination will be imposed in the manner provided for summary suspension.

(e) **Right to be heard after suspension or termination.** An AHP whose right to perform services has been suspended or terminated or whose application for rights to perform services in the Medical Center has not been approved as requested may challenge the decision and request a hearing by submitting a written statement to the Credentials Committee and the Chief Clinical Officer of the Medical Center setting forth the grounds for concern and the supporting facts. The sponsoring staff member, if any, of an AHP may also challenge the decision by submitting a written statement to the Credentials Committee and the Chief Clinical Officer of the Medical Center setting forth the grounds for concern and the supporting facts. The Credentials Committee will provide the AHP notice of the time, place and information to be considered regarding the AHP no less than three (3) days in advance of the hearing of the Credentials Committee. The Credentials Committee will include an AHP in the body making a decision regarding the AHP. The decision of the Credentials Committee (that includes the peer AHP for the remaining portion of this subsection e and f) will be issued to the AHP no later than five (5) business days after the date of the hearing, unless circumstances warrant additional time. The decision will be issued in writing by the Chief Clinical Officer summarizing the findings and decision of the Credentials Committee.

(f) **Right to Appeal.** The AHP, whose right to perform services has been suspended or terminated, and that decision has been upheld by the Credentials Committee, may appeal to the Board. If such appellate review is not requested within ten (10) days of the Credentials Committee's decision, the AHP will be deemed to have waived his or her right to appeal. Within ten (10) days after receipt of such notice of request for appellate review, the Board will appoint no less than two (2) Board members to hear the appeal ("Panel"). The Panel will schedule a date for such review including a time and place and invite the AHP, who may be represented by counsel. The appellate review by the Panel will be as soon as practicable. The AHP and the Panel will have access to the report of the Credentials Committee. The appeal proceeding is not to be a complete rehearing of all matters presented before the Credentials Committee. New facts or information not presented to the Credentials Committee should not be considered by the Panel except under unusual circumstances. Within five (5) business days of the hearing,

the Panel will make a written report recommending that the Board affirm, modify or reverse the decision of the Credentials Committee.

## **8.7 Residents.**

(a) **Qualifications.** Residents are physicians who are either in their first year of postgraduate training or otherwise participate in a medical training program. The resident's rights to perform services in the Medical Center terminate when the resident's training is completed, unless the resident sooner resigns or is dismissed from the training program. Additionally, the provisions of Section 8.6 regarding suspension and termination of AHPs shall also apply to residents.

(b) **Prerogatives.** A resident may provide those services at the Medical Center as are granted to the resident under appropriate supervision; may attend, without a vote, meetings of the staff, service, and/or other clinical unit designations as applicable; and may vote on matters presented to committees to which the resident is appointed a voting member. A resident has no staff membership prerogatives including no right to vote at meetings of the staff or any of its clinical units or to hold office in the Medical Staff organization.

(c) **Responsibilities.** A resident must:

(i) meet the requirements of the resident's residency program.

(ii) contribute to the organizational and administrative affairs of the Medical Staff by participating on staff, service, or other clinical unit designations as applicable, and committees as reasonably requested, and by participating in fulfilling such other staff functions as are reasonably requested.

(iii) attend, as requested, regular and special meetings of the service, or other clinical unit designations as applicable to which the resident is assigned and of committees to which the resident is appointed.

(d) **Supervision.** Residents shall be supervised by their preceptor-physician. Any and all orders or documentation of patient care shall be countersigned by the precepting physician, or the attending physician. The preceptor or attending physician may change a statement made in the record by a resident by initialing such a change.

## **ARTICLE IX MEDICAL STAFF OFFICERS**

**9.1 Officers of the Medical Staff.** The officers of the Medical Staff will be:

- a) Chief of Staff
- b) Vice Chief of Staff
- c) Immediate Past Chief of Staff
- d) Secretary-Treasurer

**9.2 Qualifications of Officers.** Officers must be members of the active Medical Staff at the time of

nomination and election, and must remain active staff members in good standing during their term of office. Failure to maintain such status will immediately create a vacancy in the office involved.

### **9.3 Election of Officers.**

(a) **Vice Chief of Staff and Secretary-Treasurer.** The Vice Chief of Staff, the Secretary-Treasurer will be elected by secret ballot by Members of the Active Medical Staff from among those nominated for the offices. Only members of the Active Medical Staff will be eligible to vote. Election will be held prior to an Annual Meeting of the Medical Staff and will be by secret ballot by Members of the Active Staff. A written notice of election, including an explanation of procedures for nominations will be sent to voting Members at least two (2) months prior to the election. A nominee will be elected upon receiving the largest amount of the valid votes cast. If there is a tie for the largest amount, a run-off election will be held between the candidates with the tied amounts.

(b) **Automatic Assumption of Office.** The Chief of Staff will, upon completion of a term of office in that position, immediately succeed to the office of Past Chief of Staff and the Vice Chief of Staff will immediately succeed to the office of Chief of Staff.

(c) **Nominations.** A Nominating Committee of three appointed by the Chief of Staff, chaired by the most immediate past Chief of Staff, and containing at least one non-member of the Executive Committee, will nominate at least one candidate for each office. Additional nominations may be made by any voting member of the Medical Staff, provided that the candidate is supported by a written endorsement by ten (10) additional voting Members of the Staff and by the candidate's written consent, submitted to the Chairperson of the Nominating Committee at least one month prior to the election.

**9.4 Term of Office.** Each officer will be elected to serve for a term of three years commencing on July 1. Each officer will serve until the end of his or her term or until a successor is selected. No individual may serve two consecutive terms in one office, except with the consent of two-thirds of the voting members of the Executive Committee.

**9.5 Vacancies of Office.** Vacancies in office during the Medical Staff year, except for the Chief of Staff, will be filled by the Executive Committee of the Medical Staff at its next meeting. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve out the remaining term. If there is a vacancy in the office of Past Chief of Staff, the physician on the active staff proposed for appointment to fill the remaining term must have served as Chief of Staff in the past.

**9.6 Removal of an Officer.** Permissible basis for removal of a Medical Staff officer include, without limitation, resignation from the staff, loss of active staff status, imposition of corrective action, failure to meet the requirements of Section 3.3(b), just cause, as determined by 2/3 majority vote of the active staff members, including but without limitation, physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office; failure to perform the duties of the position held in a timely and appropriate manner or failure to continuously satisfy the qualifications for the position.

### **9.7 Duties of Officers and the Chief Clinical Officer.**

(a) **Chief of Staff.** The Chief of Staff will serve as the chief administrative officer of the Medical Staff. As such he or she will:

- (1) Act in coordination and cooperation with the Chief Executive Officer and Chief Clinical Officer in all matters of mutual concern within the Medical Center;

- (2) Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and its Executive Committee;
- (3) Serve as the chairperson of the Executive Committee;
- (4) Serve as an ex-officio member of all other Medical Staff committees without vote, unless these Bylaws specifically state that the Chief of Staff is a member of a standing committee in which case he or she will have a vote;
- (5) Be responsible for the enforcement and implementation of these Bylaws and Medical Staff Policies, for implementation of sanctions where these are indicated and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a practitioner, and for enforcement and implementation of the articles of incorporation, code of regulations and bylaws of the Medical Center as they relate to the staff;
- (6) Appoint Medical Staff committee members to all standing, special and multi-disciplinary Medical Staff committees except the Executive Committee;
- (7) Represent the views, policies, needs and grievances of the Medical Staff to the EVP for Clinical Affairs, the Chief Clinical Officer and to the Board;
- (8) Transmit the policies of the Medical Staff to the Medical Staff and be accountable to the Board, in conjunction with the Executive Committee, for the quality and efficiency of clinical services and performance within the Medical Center and for the effectiveness of the patient care and quality assurance functions and other responsibilities delegated to the staff;
- (9) Be the spokesman for the Medical Staff in its external professional and public relations;
- (10) Be responsible for compliance with the requirements of The Joint Commission; and
- (11) Be responsible for: the receipt and accumulation of all information requested from the NPDB; reporting formal disciplinary actions and adverse professional review actions taken against the clinical privileges or Medical Staff membership of physicians, dentists, or other practitioners to the NPDB and State Medical Board; maintaining the confidentiality of adverse action reports filed with the NPDB, requests for information disclosure, and report verification documents; maintaining oversight for the appropriate Medical Staff committees, including the Credentials Committee and peer review committees with regard to the receipt of information from the NPDB at the time an individual applies for clinical privileges or Medical Staff membership or reapplies for Medical Staff membership or clinical privileges.

(b) **Vice-Chief of Staff.** In the absence of the Chief of Staff or for matters under Article VI which may involve the Chief of Staff, the Vice Chief of Staff will assume all the duties and have the authority of the Chief of Staff. He or she will be a member of the Executive Committee. The Vice Chief of Staff will also perform such additional duties as may be designated by the Chief of Staff, the Executive Committee or the Board.



(c) **Past Chief of Staff.** The Past-Chief of Staff will be an advisor to the Chief of Staff, will be a member of the Executive Committee and will perform such other duties as may be assigned to him or her by the Chief of Staff, the Executive Committee, or the Board. [In the event the elected Chief of Staff is not an M.D./D.O., the M.D./D.O. Past Chief of Staff will serve as a medical administrative officer to oversee clinical review].

(d) **Secretary-Treasurer.** The Secretary-Treasurer will be a member of the Executive Committee. In addition, the Secretary-Treasurer will be responsible for:

- (1) Giving the proper notice of all general staff meetings on order of the appropriate authority;
- (2) Preparing and maintaining accurate and complete minutes of all general staff meetings or monitoring the preparation and maintenance of minutes of all such meetings; and
- (3) Performing such other duties as ordinarily pertain to the office or which may be assigned by the Chief of Staff, the Executive Committee, or the Board.

(e) **Chief Clinical Officer.** Although not an Officer of the Medical Staff, the Chief Clinical Officer is appointed by the Board of Trustees and is responsible for supervising activities of the Medical Staff relating to credentialing, privileging, and to the accreditation status of the Medical Center. For effective communication, the Chief Clinical Officer will attend all meetings of the Board of Trustees that include matters with regard to the Medical Center.

(f) **Administrative Duties and Insurance.** The Medical Center will provide insurance for actions arising solely out of a Medical Staff member's performance of *administrative duties* required of him or her as a member of the Medical Staff. The administrative services referenced in the preceding sentence will include reviewing initial and reappointment applications for Medical Staff membership, clinical privileges or specified services; recommending corrective action; participating in hearings to determine corrective action; conducting patient care audits and utilization reviews; and participating in other Medical Center administrative duties, Service, committee or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct. Under no circumstances will the insurance provided by this Article be deemed to extend to the costs or expenses of claims, actions, suits or proceedings arising out of the professional services rendered by a member of the Medical Staff to a patient.

## ARTICLE X CLINICAL SERVICES

**10.1 Organization of Clinical Services.** Professional practice in the Medical Center will be divided into the following services for the primary purpose of monitoring the quality of patient care in the Medical Center:

- Anesthesiology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Neurology
- Obstetrics and Gynecology
- Orthopedics
- Pathology

- Pediatrics
- Psychiatry
- Radiology
- Radiation Oncology
- Surgery
- Urology

**10.2 Functions of Services.** Each Service will have the initial responsibility to observe patient care in the Medical Center; to strive to meet the goals of providing care that is safe, effective, patient centered, timely, efficient and equitable; and work with the Chief Clinical Officer and Executive Committee to meet these goals.

In carrying out these responsibilities, each Service will:

(a) Conduct audits of patient care within the jurisdiction of the service meeting at least the minimum requirements of The Joint Commission or of law, whichever is stricter.

(b) Make recommendations to the Executive Committee and the Board concerning Medical Staff Policies relating to the qualifications for the granting of clinical privileges of Licensed Practitioners within the Service and submit the recommendations concerning privileges of staff members and applicants for staff membership;

(c) Conduct appropriate continuing education programs and recommend to the Executive Committee requirements for such programs;

(d) Continually monitor compliance with these Bylaws and Policies of the Medical Staff, Medical Center rules, regulations, and policies, requirements for alternate coverage and for consultations, sound principles of clinical practice, and safety regulations;

(e) Coordinate the work of the Service's members with nursing and ancillary patient care services, administrative support services, and with staff and multi-disciplinary committees in conjunction with the Chief Clinical Officer;

(f) Submit written reports on a regular basis to the Executive Committee concerning findings of the Service's audit activities, actions taken thereon, the results of such actions, recommendations for maintaining and improving the quality of care provided in the Service and in the Medical Center, and such other matters as may be reasonably requested from time to time by the Executive Committee or the Chief Clinical Officer;

(g) If the Service has more than two (2) members, meet at least bi-monthly for the purpose of receiving, reviewing and considering patient care audit findings and the results of the Service's other review, evaluation, and education activities and for the purpose of performing or receiving reports on other Service or Staff functions;

(h) Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it; and

(i) In the case of a particular Service, make recommendations to the Executive Committee and the Board concerning policies governing the provision of all categories of such services, including specifying the minimum qualifications for each category of practitioner, and the requirements for

supervision of each category of practitioner, if applicable.

### **10.3 Qualifications, Selection and Tenure of Service Chief.**

(a) Each Clinical Service will have a Service Chief who will also be the Chair of the corresponding academic department of the University of Toledo College of Medicine, when such a department exists, or will be a faculty member of such department designated by the Chair, and qualified for the position, as evidenced by his/her training, experience, and demonstrated ability. Each Service Chief will be a member of the Active Medical Staff, meet the qualifications set forth in Section 3.4, and be board certified or have affirmatively established through the privilege delineation process that he or she is possessed of comparable competence, and will be willing and able to faithfully discharge the duties of Service Chief.

(b) The Service Chief will be recommended to the Board of Trustees by the EVP for Clinical Affairs and Dean of the College of Medicine & Life Sciences or designee and with the concurrence of the Chief of Staff. A person recommended for Service Chief by the above mechanism will function as the interim Service Chief until the Board of Trustees acts on the appointment.

(c) The term of the previous Service Chief will end when a new service chief is recommended by the Executive Vice President for Clinical Affairs and Dean of the College of Medicine & Life Sciences or designee, with the concurrence of the Chief of Staff. A person recommended for Service Chief by the above mechanism will function as the interim Service Chief until the Board of Trustees acts on the appointment.

**10.4 Responsibilities of the Service Chief.** The Service Chief will have general supervision over the clinical work of his/her Service, and will have authority to appoint Heads of Sections, as appropriate for organizing and providing care in recognized areas of medical specialization within his/her discipline, and otherwise to delegate administrative responsibility as necessary for efficient care of patients on his/her service. Each Service Chief will be responsible for monitoring clinical work within his or her service. Each Service Chief will be responsible to and report to the Chief of Staff in collaboration with the Chief Clinical Officer. In addition, each Service Chief will perform duties as assigned by the Chief of Staff, in collaboration with the Chief Clinical Officer, in the delivery of care that is safe, effective, patient centered, timely, efficient, and equitable. Each Service Chief will:

(a) Be accountable the Chief of Staff in collaboration with the Chief Clinical Officer for all professional and administrative activities within the Service;

(b) Provide guidance on the overall medical policies of the Medical Center and make specific recommendations and suggestions regarding the Service in order to assure quality patient care;

(c) Maintain continuing surveillance of the professional performance of all practitioners with clinical privileges in the Service and report thereon to the Executive Committee and Chief Clinical Officer no less frequently than at the time of reappointment or re-approval of each such staff member;

(d) Be responsible for assuring the implementation of a planned and systematic process for continuous monitoring and evaluating of the quality and appropriateness of care and treatment of patients served by the Service, and as requested by the Chief of Staff or Chief Clinical Officer from time to time, report on the results of continuous monitoring and evaluation of the quality and appropriateness of care and treatment of patients served by the Service;

(e) Be responsible for enforcement of the mission, vision and policies and rules and

regulations of the Medical Center and of the Medical Staff Bylaws and the Policies of the Medical Staff;

(f) Be responsible for implementation within the Service of actions taken by the Executive Committee;

(g) Transmit to the Credentials Committee recommendations of the Service concerning the staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in the Service;

(h) Participate in the administration of the Service through cooperation with the Nursing Service and the Medical Center management in matters affecting patient care;

(i) Be responsible for the integration of the Service into the primary functions of the Medical Center and the coordination and integration of interdepartmental and intradepartmental services;

(j) Assist in the preparation of annual reports, including budgetary planning, pertaining to the Service as may be required by the Executive Committee, EVP for Clinical Affairs, the Chief Clinical Officer and the Board and make recommendations for space and other resources needed by the Service;

(k) Assist the Medical Center Administration in determining the qualifications and competence of Service personnel who are not licensed independent practitioners and who provide patient care services;

(l) Be responsible for the recommendations for a sufficient number of qualified and competent persons to provide care in the Service;

(m) Develop and implement policies and procedures that guide and support the provision of services; and

(n) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, the Executive Committee, the EVP for Clinical Affairs, the Chief Clinical Officer or the Board.

**10.5 Chief of Anesthesiology Service.** The Chief of the Anesthesiology Service will have authority and responsibility for directing the administration of all anesthesia services throughout the Medical Center, including planning, directing and supervising all anesthesia activities, and evaluating the quality and appropriateness of anesthesia care.

## **10.6 Clinical Services**

(a) **Meetings of Clinical Services.** Each Clinical Service will hold meetings to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to the patients. A written report will be maintained and provided to the Chief Clinical Officer and Executive Committee which will include the names of the staff Members in attendance and will include resultant conclusions, recommendations, actions, and monitors.

(b) **Member's Responsibility.** The Members of each Service will work collaboratively with the Chief Clinical Officer and will be directly responsible to the Chief of that Service and the Department Chair, and through him/her, to the Chief of Staff in collaboration with the Chief Clinical Officer.

(c) **Functions of Services.** All Services will establish their own criteria consistent with the policies of the Medical Staff and of the Board of Trustees, for the granting of clinical privileges, and for the evaluation of the quality and appropriateness of patient care within the Service. All Services will meet

separately and regularly to review and analyze on a peer group basis the clinical work of the Service. Such Service analyses of patient care will be reported to the Executive Committee with comment and recommendation detailing each Service's analysis of patient care. These analyses will then be reported in summary to the Board of Trustees.

## **ARTICLE XI MEDICAL STAFF COMMITTEES**

### **11.1 Staff Committees.**

(a) **Duties.** The various staff committees will be responsible for implementing and monitoring functions delegated to the staff by the Board. Each committee will make recommendations to the Executive Committee for the adoption of programs and procedures for the functions delegated to the committee. Each committee will be responsible for implementing and monitoring all programs and procedures that pertain to the functions delegated to the committee and will report to the Executive Committee the nature of such programs and procedures, their efficacy, and recommendations, if any, for improving them. The Executive Committee will then make a similar report to the appropriate quality assurance or peer review committees or the Board. The Board shall adopt such programs and procedures as it deems advisable. Each committee shall be responsible for implementing and monitoring all programs and procedures adopted by the Board that pertain to the functions delegated to the committee and shall report to the Executive Committee the nature of such programs and procedures, their efficacy, and recommendations, if any, for improving them. The Executive Committee shall then make a similar report to the Board for its action.

In discharging its duties, each committee shall be responsible for determining the requirements of The Joint Commission and the law applicable to the functions assigned to it and for reporting to the Executive Committee such requirements, significant changes in those requirements during the preceding year, and whether the Medical Center complies with all of the requirements. If the committee has determined that the Medical Center does not comply with all such requirements, the committee shall make recommendations on what should be done to comply with such requirements.

All staff committees will be subject to the immediate supervision of the Executive Committee. The committee will provide minutes of all meetings to the Executive Committee.

(a) **Composition.** All staff committees will be created by the Executive Committee. All Medical Staff committees, other than the Executive Committee will be appointed by the Chief of Staff and approved by the Executive Committee. The clinical qualifications of the staff members will be relevant to their responsibilities within the organizational structure. The chair of each staff committee will be appointed by the Chief of Staff subject to approval by the Executive Committee. The Chief of Staff and the Chief Clinical Officer will be ex-officio members without a vote of all staff committees, except for the Joint Conference Committee. Minutes of all staff committee meetings will be available to the Executive Committee, the Chief Clinical Officer and the Board.

### **11.2 The Executive Committee.**

(a) **Composition.** The Executive Committee will consist of the officers of the Medical Staff and the Chiefs of each clinical service, and two members appointed by the Chief of Staff in consultation with the Chief Clinical Officer and EVP for Clinical Affairs. The Chief Executive Officer or designee will be an ex-officio member without vote. The Chief Clinical Officer and EVP for Clinical

Affairs shall be ex-officio members with a vote. The Chief of Staff will be the Chair.

(1) The at-large members will serve for a term of three (3) years and for not more than two (2) consecutive terms. Vacancies shall be filled by appointment of the Chief of Staff.

(2) When a non-elected member of the Executive Committee must be absent from regular meetings, he/she may be represented by a designated alternate who must be an Active member of the Medical Staff. Either the non-elected member or his/her designee must attend at least fifty percent of the meetings held annually.

(b) **Duties.** The duties of the Executive Committee will be to:

(1) Ensure compliance with these Bylaws and to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

(2) Coordinate the activities and policies of the various services and committees of the staff and to coordinate the activities and general policies of the various Clinical Services with the Chief Clinical Officer;

(3) Receive and act upon Medical Staff service reports, committee reports, quality assurance activities and the resulting recommendations and to recommend actions to the Board in matters related to quality assurance and professional review activity;

(4) Review, approve and implement new, amended, or revised policies of the Medical Staff;

(5) Make recommendations to the University on matters of medical administration and to provide an avenue of communication between the Medical Staff and the Medical Center Administration and the Board of Trustees;

(6) Consider and act upon all matters which pertain to the care of patients in the Medical Center and the professional conduct and activity of Members of the Medical Staff including reports or recommendations of any professional review body, and to report such matters to the Board of Trustees with recommendations for final actions and to make recommendations on Medical Center Management matters;

(7) Be accountable to the Board for the medical care rendered to the patients in the Medical Center and in collaboration with the Chief Clinical Officer help organize a Quality Assessment and Improvement Program described in a written plan that is reviewed annually by the Medical Staff;

(8) Serve in the capacity of an accreditation committee, and to keep the Medical Staff informed on matters related to the Joint Commission and ensure that the Medical Staff is kept informed of the accreditation program and informed of the accreditation status of the Medical Center;

(9) Review the credentials of all applicants and Medical Staff members and to make recommendations for staff appointment and reappointment, assignments to services, delineation of clinical privileges, and corrective action and to request evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;

(10) Review periodically the performance and clinical competence of staff members and other practitioners with clinical privileges, and as a result of such reviews to make recommendations for reappointment and renewal or changes in clinical privileges and corrective action, if necessary;

(11) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation or participation in Medical Staff corrective or review measures when warranted;

(12) Be empowered to act for the Medical Staff in the intervals between Medical Staff meetings; and

(13) Make recommendations directly to the Board on at least the following;

- i. Medical Staff membership;
- ii. the organized Medical Staff's structure;
- iii. the process used to review credentials and delineate privileges;
- iv. the delineation of privileges for each practitioner privileged through the Medical Staff process.

(c) **Accreditation.** The Executive Committee will also be responsible, along with Medical Center Administration, for the acquisition and maintenance of accreditation by The Joint Commission. From time to time, it will require that The Joint Commission survey for purposes of constructive self-criticism. It will identify areas of possible non-compliance with The Joint Commission and will make recommendations to the Executive Committees of the Board and of the Medical Staff.

(d) **Disaster Planning.** The Executive Committee will be responsible for the development and maintenance of methods for the protection and care of Medical Center patients and others during any disaster. Specifically, it will:

(1) Recommend and periodically review a written plan to safeguard patients at the time of an internal disaster.

(2) Recommend and periodically review a written plan for the care, reception and evacuation of mass casualties in the event of an external disaster, and will assure that such plans are coordinated with the inpatient and outpatient services of the Medical Center, that it adequately reflects developments in the Medical Center, community and the anticipated role of the Medical Center in the event of disasters in nearby communities.

(e) **Meetings.** The Executive Committee will meet at as often as is required as determined by the Chief of Staff and maintain a record of its proceedings and actions.

(f) **Voting Status.** Members of the Executive Committee who are not members of the Medical Staff are not eligible to vote on matters before the Executive Committee.

(g) **Policies of Medical Staff.** The Executive Committee will approve and promptly post on an electronically available location or website any approved Medical Staff Policy.

(h) **Staff Functions.** Provision will be made in these Bylaws or through resolution of the Executive Committee, approved by the Board, either through assignment to the specific services lines, to staff committees, to staff officers, to interdisciplinary Medical Center committees, for the effective performance of staff functions specified in this Section as the Executive Committee or Board will reasonably require:

- (1) Monitor, evaluate, and improve care provided in and develop clinical policy for special care areas, such as but not limited to 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 but not limited to review of invasive procedures, blood dosage, drug usage reviews, medical records, and other reviews. The scope and nature of these activities can be modified from time to time as required by evolving standards and issues within the profession of Medicine or as required by external agencies;
- (3) Conduct or coordinate utilization review activities;
- (4) Conduct or coordinate credentials investigations for staff membership and grants of clinical privileges and specified services (which may specifically include the Board Committee);
- (5) Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs;
- (6) Investigate and control nosocomial infections and monitor the Medical Center's infection control program;
- (7) Plan for response to fire and other disasters, for Medical Center growth and development, and for the provision of services required to meet the needs of the community in collaboration with the Chief Clinical Officer;
- (8) Direct staff organizational activities, including staff Bylaws review and revision, staff officer and committee nominations, liaison with the Board and Medical Center administration, and review and maintenance of Medical Center accreditation;
- (9) Coordinate the care provided by Members of the Medical Staff with the care provided by the nursing service and with the activities of other Medical Center patient care and administrative services;
- (10) Collect, investigate, and address clinical practice concerns regarding complaints received from patients, families and any other source including medical center staff.
- (11) Engage in other functions reasonably requested by the Executive Committee, the Chief Clinical Officer or the Board.



### 11.3 The Credentials Committee.

(a) **Composition.** The Credentials Committee will consist of members of the active Medical Staff selected by the Chief of Staff on a basis that will insure representation of the major clinical specialties and the Medical Staff at large, plus three members of Legal Affairs/Risk Management. For purposes of taking the action required by Section 5.4(c) only, the Service Chiefs not already members of the Credentials Committee will be members of the Credentials Committee and the committees appointed by the Service Chief under Section 5.4(c) will be subcommittees of the Credentials Committee. The Service Chief may be required to attend the Credentials Committee meeting.

(b) **Duties.** The duties of the Credentials Committee will be to:

(1) Review and evaluate the credentials of all applicants for initial appointment, reappointment, or, modification of appointment to privileges and to membership on the staff, to investigate the health status of each, to obtain and consider the recommendations of the appropriate Service Chief, and to make recommendations for membership, staff category, and service division, and delineation of clinical privileges and any special conditions on privileges in compliance with Articles V and VI of these Bylaws;

(2) Make a report to the Executive Committee on each such applicant for Medical Staff membership or clinical privileges which includes specific consideration of the recommendations from the Services in which such applicant requests privileges and a recommendation for membership, staff category, Service division, and delineation of clinical privileges and any special conditions on privileges;

(3) Investigate any reported breach of ethics unless the Chief of Staff directs that such investigation be conducted by an investigation committee pursuant to Section 6.2(b); and

(4) Review reports that are referred by any committee and the Chief of staff.

(c) **Meetings.** The Credentials Committee will meet as often as necessary, no less than yearly and will keep minutes. The quorum and manner of voting is set forth in Medical Staff policy.

### 11.4 The Joint Conference Committee.

(a) **Composition.** The make-up of the Joint Conference Committee is set forth in Article XVII, Section 17.1. Any person who holds a conflict with respect to the issue before the Joint Conference Committee will be replaced with another person appointed by the Vice Chief of Staff.

(b) **Mandatory Referral.** The Board will refer to the Joint Conference Committee for investigation and advice all matters relating to a person's staff membership, privileges, or status where the Board has voted to take action inconsistent with the last formal action on the matter taken by the staff or an appropriate committee or service of the staff.

(c) **Meetings.** The Joint Conference Committee will meet whenever a matter is referred to it.

**ARTICLE XII  
MEDICAL STAFF MEETINGS**

**12.1 Annual Staff Meeting.** A meeting of the full Medical Staff will be held each year. The agenda of such meeting will include appropriate topics necessary for review. Each member of the Medical Staff will be requested to attend the regular annual meeting of the Medical Staff. The Chief of Staff will set the date, time and place of the annual meeting.

**12.2 Special Meetings of the Medical Staff.** The Chief of Staff, the Chief Clinical Officer, the Executive Committee, the Board or not less than one-fourth of the members of the active Medical Staff at any time may file a written request with the Chief of Staff requesting a special meeting of the medical staff and designating the business to be transacted at the special meeting. Within two (2) business days of the filing of such request, a special meeting of the Medical Staff will be called if the Chief of Staff concurs. The Chair of the Executive Committee will determine when meetings of the Executive Committee meetings are to be held. The Chair of the Credentials Committee will determine when meetings of the Credentials Committee are to be held.

**12.3 Designation of Date, Time and Place.** The Chief of Staff or Executive Committee will designate the time and place of the annual meeting and any such special meeting properly called.

**12.4 Notice of Medical Staff Meetings.** A notice of the annual or special meetings of the medical staff will sent by the Chief of Staff or designee, to each member of the active Medical Staff by telephone or electronic mail. Such notice will contain the date, time, place and agenda of the meeting and will be provided no earlier than thirty (30) days before such annual or special meeting and no later than two (2) days prior to such meeting.

**12.5 Agenda.**

(a) The agenda of the annual Medical Staff meeting will typically include but not be limited to the following, as determined by the Chief of Staff:

- (1) Call to order;
- (2) Acceptance of the minutes of last regular and all subsequent special meeting;
- (3) Unfinished business;
- (4) Communications;
- (5) Report from the Chief Clinical Officer;
- (6) Reports of Services;
- (7) Reports of committees;
- (8) New business (including elections);
- (9) Professional review and analysis of the clinical professional work of the Medical Center;
- (10) Discussion and recommendations for improvement of professional services within the Medical Center;
- (11) Adjournment;

(b) The agenda at special meetings should include the following, as determined by the Chief of Staff:

- (1) Reading of the notice calling the meeting;
- (2) Transaction of business for which the meeting was called;
- (3) Adjournment.

**12.6 Quorum.** The following, in totality, will constitute a quorum of active Medical Staff members for the annual or a special meeting of the Medical Staff to transact business for such meeting properly called, or a quorum of Committee voting members to transact business Executive of Credentials Committee at a meeting properly called:

- (a) Members personally present at the meeting;
- (b) Members attending by phone or by other electronic communications/means;
- (c) Members submitting a vote to the Medical Staff office in advance in compliance with these Bylaws; or
- (d) Members granting a proxy by an active medical staff member to another active member who is present.

**12.7 Action.**

The action of a majority of the members who are counted for purposes of a quorum in Section 12.3 above will be the action of the Medical Staff. Members of the Medical Staff will be permitted to vote provided such vote is submitted in writing to the Medical Staff office in advance of the meeting and as long as the substance of item under consideration for vote has not been amended. Submission in writing includes return of a written ballot or an approved electronic mail method. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of remaining members.

**12.8 Waiver of Notices for Meetings.** No staff member will be entitled to complain that the member has not received written or proper notice of an annual, special meeting or Executive or Credentials Committee meeting or the subject matter to be discussed at such meeting if that member:

- (a) Attended the meeting in person, by phone or by other electronic means;
- (b) Voted in advance on the business transacted at the meeting as set forth above; or
- (c) Failed to receive notice because the member failed to provide the Medical Center with a current email and mailing address.

### **ARTICLE XIII CLINICAL SERVICE MEETINGS**

**13.1 Clinical Service Meetings.** Clinical Services will meet as necessary at the discretion of the Service Chief or as requested by the Chief Clinical Officer to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of care and treatment provided to patients. If the Clinical Service meeting is not held, (e.g., due to inclement weather), monitoring and evaluation will continue to be reported and reviewed at the next regular meeting of the Service.

**13.2 Committee Meetings.** Each committee will set a time for holding its regular meetings. Medical Staff committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

**13.3 Special Meetings.** A special meeting of any committee or Service may be called by or at the request of the Chairperson or Service Chief thereof, by the Chief of Staff, or by one-third of that committee's or Service's members, but not less than two (2) members. Committee members will be

notified in advance of such special meeting by the committee Chairperson or Service Chief.

**13.4 Quorum.** No less than two members will constitute a quorum for holding a meeting.

**13.5 Manner of Action.** The action of a majority of the members present at a meeting at which a quorum is present will be the action of a committee or Service. A meeting of a Clinical Service of committee should follow Robert's Rules of Order unless waived, except that the chairperson of any meeting may vote.

**13.6 Rights of Ex Officio Members.** Persons serving under these Bylaws as ex officio members of a committee will have all rights and privileges of regular members except they will not be counted in determining the existence of a quorum, and they will not have the right to vote.

**13.7 Minutes.** Minutes of each regular and special meeting of a committee or Service will be kept and will include a record of members in attendance and the vote taken on each matter. The minutes will be forwarded to the Executive Committee.

#### **ARTICLE XIV CONFLICT RESOLUTION**

**14.1 Conflicts between the Board and the Medical Staff.** The following process will be followed before the Board takes any action on any amendment or addition to the Medical Staff Bylaws or Policies that is inconsistent with the position of the Medical Staff or the Executive Committee (as to matters within its delegated authority):

(a) The matter will be submitted to the Joint Conference Committee for discussion and recommendation in accordance with Section 11.4(c).

(b) If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than would be possible under this conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the Medical Center, the Board may take action on such matters.

**14.2 Conflicts between the Medical Staff and the Executive Committee.** The following process will be followed in addressing any situation in which the Medical Staff takes any action concerning a Medical Staff [Rule or Regulation] or Policy under Article XV that is inconsistent with the position of the Executive Committee as to matters within its delegated authority:

(a) The Executive Committee will meet with a representative group of the Medical Staff, as determined by the entire Medical Staff, and seek to resolve the conflict through discussions. The Executive Committee and the Medical Staff representatives will make best efforts to collaborate together to resolve the issue. Any resolution arrived at during such meeting or thereafter will be subject to the approvals of the Executive Committee and the Medical Staff.

(b) If, after ninety (90) days from the date of the initial request for the meeting described in subsection (a), the Executive Committee and the Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Medical Staff will have the authority to act on the issue that gave rise to the conflict, subject to the approval of the Board.

**ARTICLE XV**  
**MEDICAL STAFF POLICIES AND**  
**MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS**

**15.1 Medical Staff Policies.**

(a) The Medical Staff will adopt such Policies as may be necessary to implement more specifically the general principles found within these Bylaws as a delegated authority from the Board. These Policies will relate to the proper conduct of Medical Staff activities as well as embody the level of practice that is to be required of each practitioner in the Medical Center. Such Policies will be published in addition to these Bylaws.

- (1) Medical Staff Policies may be enacted, amended or repealed by action of the Medical Staff acting through the Executive Committee.
- (2) The Executive Committee will adopt such Policies as may be necessary to implement the general principles of these Bylaws, govern and organize the Services, and to establish criteria for the granting of clinical privileges, and for the holding of office in the Services. The Medical Staff Policies and any amendments thereto will become effective when approved by the Executive Committee. The Executive Committee will notify the voting members of the Medical Staff of any action to adopt, amend or repeal a Policy or any portion thereof when necessary and proper.
- (3) Members of the Medical Staff may take policies or amendments to policies directly to the Medical Staff for approval or disapproval, without first taking such amendment to the Executive Committee. Such policies or amendments will be adopted if at least fifty (50%) percent of the total eligible voting Members approve of the policy or amendment in writing. "In writing" includes return of a written ballot or an approved electronic mail method with a clear vote in favor of the policy or amendment.

**15.2 Medical Histories and Physical Examinations.**

(a) A medical history and physical examination appropriate to the patient's condition and level of care will be completed by the admitting physician, dentist, podiatrist or other qualified practitioner and present on the medical record no more than thirty (30) days before or twenty four (24) hours after admission or registration, but prior to any invasive procedure or sedation, other than minimal sedation. In an emergency, when there is no time to record the complete history and physical examination, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis must be recorded in the medical record before the surgery or other operative procedure is performed. Entries must be signed, dated and timed.

(b) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty four (24) hours after admission or registration, but prior to any invasive procedure or sedation, other than minimal sedation, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, new diagnoses, new medications or allergies or a statement indicating no changes exist since the prior evaluation, must be completed and documented by the admitting physician, dentist, podiatrist or other qualified practitioner. Entries must be signed, dated and timed.

**ARTICLE XVI  
AMENDMENTS TO BYLAWS**

**16.1 Amendments initiated by staff**

(a) The staff will have the initial responsibility and delegated authority to formulate and recommend to the Board Bylaws for the staff and amendments thereto. Such responsibility and authority will be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of patient care in and the best interests of the Medical Center and of maintaining a harmony of purpose and effort among the Board, the Medical Center Administration, the Medical Center's Medical Staff and the community.

(b) A proposed amendment to these Bylaws will be referred to the Executive Committee which will consider the proposal, then reject, revise or develop the amendment. If approved, the amendment or a version of the amendment will be forwarded to the Medical Staff for consideration at the annual meeting or a special meeting of the Medical Staff called for such purpose. To be adopted, the Bylaws amendment will require a majority vote of the Medical Staff present as set forth Section 12.4, provided a quorum is present as defined in Section 12.3.

(c) Members of the Medical Staff may take an amendment of these Bylaws directly to the Medical Staff for approval or disapproval, without first taking such amendment to the Executive Committee if at least fifty (50%) percent of the total eligible voting Members approve, in writing, of putting the amendment to a vote to the full Medical Staff. A special meeting will be called by the Chief of Staff. The quorum and manner of voting will comply with Article 12.

(d) Any amendment to these Bylaws approved through either Section 16.1(b) or (c) above will then be presented to the Board for approval and adoption in accordance with the authority and regular proceedings of the Board.

**16.2 Amendments initiated by the Board.** In the event that the staff fails to exercise its responsibility and authority under Section 16.1, the provisions of Article II will apply.

**16.3 Amendments and Effective Date.** Unilateral amendment of these Bylaws, by the Executive Committee or the Board of Trustees, is prohibited. This rule in no way is intended to create a contractual right between The University of Toledo and any practitioner. These Bylaws and any amendments thereto will be effective when adopted by the Board.

**ARTICLE XVII  
DEFINITIONS, GENERAL PROVISIONS**

**17.1 Definitions.**

(a) **“Allied Health Practitioner”** or **“AHP”** means any of the following:

Any type of licensed independent practitioner approved by the Medical Staff and the Board as an Allied Health Practitioner.

(b) **“Anesthesiology services”** means the administration of medication in order to help the patient tolerate diagnostic or therapeutic procedures, and including general anesthesia, regional anesthesia, moderate and deep sedation and analgesia for anesthesia purposes.

(c) **“Board”** means the Board of Trustees of The University of Toledo or a committee of the

Board to which it has delegated authority.

(d) **“Business day”** means a day other than a Saturday, a Sunday, or an Ohio or federal legal holiday.

(e) **“Category”** or **“staff category”** refers to the categories of staff established by Article IV.

(f) **“Executive Vice President for Clinical Affairs,” “EVP for Clinical Affairs”** or **“EVP”** means the Associate Dean for Medical Affairs or his or her equivalent.

(g) **“Chief of Staff”** means the individual elected by the members of the Active Medical Staff to serve as the administrative head of the Medical Staff and the Chair of its Executive Committee. The Chief of Staff must be a Doctor of Allopathic Medicine, a Doctor of Osteopathic Medicine or a Podiatrist.

(h) **“Clinical Service(s)”** means those professional practice groups in the Medical Center divided into the services for the primary purpose of monitoring the quality of patient care in the Medical Center as set forth and determined by the Executive Committee as set forth in Article X.

(i) **“Executive Committee”** means the Medical Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff will conduct all business of the Staff within the contemplation of these Bylaws, unless action and review by the entire Staff are specifically required.

(j) **“Medical Center”** means the University of Toledo Medical Center and all University owned and operated clinics and health care facilities which are part of the legal entity, The University of Toledo.

(k) **“Medical Center Administration”** mean administrators in charge of overseeing the operations of the Medical Center.

(l) **“Joint Conference Committee”** means a standing committee composed five (5) members: the Chief of Staff; an additional member of the Executive Committee; the Chair of the Clinical Affairs Committee of the Board; the EVP for Clinical Affairs; and the Chief Clinical Officer.

(m) **“Medical Staff”** or **“Staff”** means the organized group of licensed medical physicians, dentists, podiatrists, and psychologists who are members of the Medical Staff of the Medical Center pursuant to these Bylaws.

(n) **“Licensed Practitioner”** means any individual permitted by law and by the Medical Center to provide care and services, without direction or supervision, within the scope of the individual’s license and any Allied Health Practitioner permitted by law and by the Medical Center to provide care and services within the scope of the individual’s license.

(o) **“Chief Clinical Officer”** means the person appointed by the Board to serve as the chief medical officer for the Medical Center or his/her equivalent.

(p) **“Privileges”** means the permission to render specific diagnostic, therapeutic, medical, dental, podiatric, psychological, surgical or anesthesia services to patients in the Medical Center.

(q) **“Service Chief(s)”** mean those members of the Medical Staff that are appointed to heads of the respective services for clinical oversight and with regard to the duties set forth in these Medical Staff

Bylaws.

**17.2 Notices.** Unless otherwise expressly provided by these Bylaws, all notices given under these Bylaws or in connection with these Bylaws will conform to the requirements of this section. All notices conforming to this section will be sufficient for all purposes of these Bylaws.

(a) **Staff members.** Any notice to any staff member or applicant or staff membership and privileges will be effective when actually received by the person by any means or when written notice is mailed by certified mail, return receipt requested, to the person's business address shown on the person's last application form or such other address as the person may have designated by written notice to the Chief Clinical Officer.

(b) **Staff officers and officials.** Any notice to any staff officer or official must be in writing and will be effective only when actually received by the officer or official.

(c) **Medical Center.** Any notices to the Medical Center must be in writing and will be effective only when received by the Chief Clinical Officer.

(d) **Elections.** Mailings to members in connection with elections need not be made by certified mail, return receipt requested.

**17.3 Computation of Time.** In computing any time period under these Bylaws: (i) the day from which the period begins will not be included; (ii) each day thereafter will be included, unless the Bylaws specify that only business days will be included; and, (iii) the last day of any period ending on a Saturday, Sunday, or Ohio or federal legal holiday will not be included and the period will end on the first business day thereafter.

**17.4 Associated Details.** Any details, requirements, or procedures related to any topic that are not explicitly included in these Bylaws will be considered associated details of that topic. Unless a provision in these Bylaws explicitly directs in which document certain associated details regarding a topic must be set forth, associated details may be set forth in the Medical Staff Policies, provided that such associated details do not conflict with these Bylaws. The revision, approval, and adoption of such associated details will be in accordance with the procedures applicable to the particular document in which the associated details are found.