University of Toledo Medical Center

MEDICAL STAFF BYLAWS

Part I: Governance

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Table of Contents

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at University of Toledo Medical Center in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the University of Toledo Board of Trustees ("University Board of Trustees") through the UToledo Health Board (UTH Board").

1.2 Authority

Subject to the oversight of the UTH Board and the ultimate authority of the University Board of Trustees the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated rules, regulations, and policies of the Medical Center. Henceforth, whenever the term "Medical Center" is used, it means the University of Toledo Medical Center. Whenever the term "CEO" is used, it shall mean the Medical Center CEO who is responsible for the overall management of the Medical Center. The term CEO includes a duly appointed acting administrator serving when the CEO is away from the Medical Center.

1.3 Definitions

1.3.1 **Advanced Practice Provider** or **APP** means those individuals eligible for privileges but not staff membership who are physician assistants (PAs), or advance practice registered nurses (APRNs) such as certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs) or certified nurse practitioners (CNPs).

1.3.2 **Allied Health Professional**" or **AHP** means those individuals eligible for privileges who are not staff Members or Advanced Practice Providers who are qualified by academic education and clinical experience or other training to provide patient care services in a clinical or supportive role. AHPs provide services only under supervision of a Member of the Medical Staff. AHPs include individuals such as medical physicists, registered nurse first assistants (RNFAs) and certified scrub techs. AHPs may also be privileged when they are independently ordering services.

1.3.3 **Application** means an application for appointment and/or privileges to the Medical Staff as described in Part III, Section 3 of the *Medical Staff Bylaws.*

1.3.4 **Appointee** means any physician, dentist, oral and maxillofacial surgeon, podiatrist, or clinical psychologist holding a current license to practice within the scope of his or her license who is a Member of the Medical Staff.

1.3.5 **Board Certification** is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery, or the American Board of Professional Psychology upon a physician, dentist, podiatrist, or clinical psychologist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice. Board certification includes any foreign board acknowledged by ABMS or AOA.

1.3.6 **Chief Executive Officer** or **CEO** is the individual who report to the UTH Board, the University President and to the Executive Vice President for Health Affairs on the overall administration of the Medical Center. The CEO may, consistent with his or her authority granted by the UTMC Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

1.3.7 **Clinical Privileges** or **Privileges** mean the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services with the Medical Center.

1.3.8 **Clinical Service** or **Service** means a grouping of like practitioners as note in Part I, Section 5 of the *Medical Staff Bylaws*.

1.3.9 **Clinical Service Chief** means an Active (Voting) Member who has been appointed in accordance with and has the qualifications and responsibilities for Service Chief as outlined in Part I, Section 5.2 of these Bylaws. For purposes of Joint Commission accreditation, Clinical Service Chiefs are Department Chairs.

1.3.10 **Days** shall mean calendar days unless otherwise stipulated in the *Medical Staff Bylaws.*

1.3.11 **Dentist** means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in Ohio. Oral and Maxillofacial Surgeons are in the category of dentists.

1.3.12 **Division** means a grouping of like practitioners which is a subdivision of a larger Clinical Service.

1.3.13 **Good Standing** means having no adverse actions, limitations, or restriction on privileges or Membership at the time of inquiry based on a reason of competence or conduct.

1.3.14 **Governing Body**, **Board of Trustees** or **Board** means the University Board of Trustees. The UTH Board has been delegated certain governing body functions, suject to the ultimate authority of the University Board of Trustees.

1.3.15 **Hearing Panel** means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner in accordance with Part II, Section 5 of these *Medical Staff Bylaws.*

1.3.16 **Medical Center** means University of Toledo Medical Center.

1.3.17 **Medical Executive Committee** or **MEC** shall mean the Executive Committee of the Medical Staff provided for in Part I, Section 6 of the *Medical Staff Bylaws.*

1.3.18 **Medical Staff** or **Staff** means that organization composed of those individuals who are either physicians, dentists, oral and maxillofacial surgeons, podiatrists, or clinical psychologists who have obtained membership status and have been granted privileges that allow them to attend patients and/or to provide other diagnostic, therapeutic, teaching or research services at the Medical Center.

1.3.19 **Medical Staff Bylaws** or **Bylaws** means these Bylaws covering the operations of the Medical Staff of University of Toledo Medical Center.

1.3.20 **Medical Staff Rules and Regulations** or **Rules and Regulations** means the rules and regulations adopted by the MEC and approved by the UTH Board.

1.3.21 **Medical Staff Year** is defined as the 12-month time period beginning on July 1 of each year and ending June 30.

1.3.22 **Member** or **Staff Member** is a physician, dentist, oral and maxillofacial surgeon, podiatrist, or clinical psychologist who has been granted this status by the UTH Board.

1.3.23 **Oral and Maxillofacial Surgeon** means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery. The term "dentist" as used in these Bylaws includes oral surgeons.

1.3.24 **Physician** means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in the State of Ohio.

1.3.25 **Podiatrist** means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Ohio.

1.3.26 **Practitioner** means an appropriately licensed physician, dentist, oral and maxillofacial surgeon, podiatrist, clinical psychologist, Advanced Practice Provider, or Allied Health Professional who has been granted clinical privileges.

1.3.27 **Prerogative** means the right to participate, by virtue of Staff category or otherwise, granted to a Practitioner, and subject to the ultimate authority of the UTH Board and the conditions and limitations imposed in these Bylaws and in other Medical Center and Medical Staff policies.

1.3.28 **Representative** or **Medical Center Representative** means the UTH Board and any board member or committee thereof; the CEO or his or her designee; other employees of the Medical Center; a Medical Staff organization or any member, officer, Clinical Service or Division or committee thereof; and any individual appointed or authorized by any of the foregoing Representatives to perform specific functions related to gathering, analysis, use or dissemination of information.

1.3.29 **Special Notice** means written notice sent via certified mail, return receipt requested or by hand delivery evidenced by a receipt signed by the Practitioner to whom it is directed.

1.3.30 **University** means The University of Toledo.

1.3.31 **Written** means documented through entry in an electronic format or on paper.

Section 2. Medical Staff Membership

2.1 Nature of Membership

Membership on the Medical Staff of the Medical Center is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, podiatrists, and clinical psychologists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated rules, regulations, policies, and procedures of the Medical Staff and the Medical Center.

2.2 Qualifications for Membership

The qualifications for Membership are delineated in Part III of these Bylaws (Credentials Procedures Manual).

2.3 Nondiscrimination

The Medical Center will not discriminate in granting staff appointment and/or clinical privileges on the basis of discriminatory factors, as noted in University policy, this is unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The UTH Board shall make initial appointment and reappointment to the Medical Staff. The UTH Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the MEC except for temporary, emergency and disaster privileges. Appointment and reappointment to the Medical Staff shall be for no more than thirty-six (36) calendar months.

2.5 Membership and Clinical Privileges

Requests for Membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the UTH Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures Manual) of these Bylaws.

2.6 Member Responsibilities

2.6.1 Each Member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.6.2 Each Member and Practitioner with privileges must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

2.6.3 Each Active (Voting) Member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department or in other Medical Center coverage programs as determined by the MEC and the UTH Board and documented in the Rules and Regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each Member and Practitioner with privileges must submit to any pertinent type of health evaluation (physical and/or mental) as requested by any two (2) of the following: Officers of the Medical Staff, CEO, Medical Center Chief Medical Officer (CMO), and/or their Clinical Service Chief, when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the member's or Practitioner's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Medical Center policies addressing Practitioner health or impairment.

2.6.5 Each Member and Practitioner with privileges must abide by these Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Medical Center.

2.6.6 Each Member and Practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount, sufficient to cover the clinical privileges granted or an amount established by the UTH Board, whichever is higher. In addition, Members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each Member and Practitioner with privileges shall notify the Medical Staff Office immediately of any and all malpractice claims filed in any court of law against the Member.

2.6.7 Each applicant for privileges or Member or Practitioner with privileges agrees to release from any liability, to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Member and his/ her credentials.

2.6.8 Each Member and Practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and Medical Center policies, the medical and other required records for all patients to whom the Practitioner provides care in the Medical Center, or within its facilities, clinical services, or departments.

a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State and Federal law and Medical Center policy.

b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and Medical Center policy.

c. The content of complete and focused history and physical examinations is delineated in the Rules and Regulations.

2.6.9 Each Member and Practitioner with privileges will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the Medical Center's business information designated as confidential by the Medical Center or its representatives prior to disclosure.

2.6.10 Each Member and Practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or UTH Board in order to properly delineate that member's clinical privileges.

2.6.11 Each Medical Staff leader shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Medical Center. Medical Staff leadership will deal with conflict of interest issues per the UT Conflict of Interest policy.

2.7 Member Rights

2.7.1 Each Member in the Active (Voting) category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such Practitioner is unable to resolve a matter of concern after working with his/her Clinical Service Chief or other appropriate Medical Staff leader(s), that Practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.7.2 Each Member in the Active (Voting) category has the right to participate in the initiation of a recall election of a Medical Staff officer by following the procedure outlined in Section 4.7 of this Part I of these Bylaws, regarding removal and resignation from office.

2.7.3 Each Member in the Active (Voting) category may participate in the initiation of a call for a general staff meeting, to be held within ninety (90) days, to discuss a matter relevant to the Medical Staff by presenting a petition signed by ten percent (10%) of the Active (Voting) category Members. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each Member in the Active (Voting) category may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any Member may submit a petition signed by ten percent (10%) of the Active (Voting) category Members. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 of this Part I will be followed.

2.7.5 Each Member in the Active (Voting) category may call for a Clinical Service meeting by presenting a petition signed by at least two (2) Members of the Clinical Service. Upon presentation of such a petition the Clinical Service Chief will schedule a Clinical Service meeting.

2.7.6 The above Sections 2.7.1 to 2.7.5 of this Part I do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.7 Any Practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these Bylaws).

2.8 Staff Dues

Annual Medical Staff dues, if any, shall be determined by the MEC. Failure of a Member to pay dues shall be considered a voluntary resignation from the Medical Staff as noted in Part II, Section 3.1.6 of these Bylaws. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.9 Indemnification

2.9.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the Medical Center and Medical Staff.

2.9.2 Subject to applicable law, the Medical Center shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Member in connection with the defense of any pending or threatened action, suit, or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the Medical Center or Medical Staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

The Medical Staff will be divided into Active, Courtesy, Membership Only and Honorary. All Members with privileges will meet the qualifications set forth in Part III, Section 2.2 of these Bylaws and have the ability to provide continuous care to their patients admitted to the Medical Center.

3.1 Active (Voting) Member Category

3.1.1 Qualifications. Members of this category consist of physicians, dentists, podiatrists, and psychologists that:

a. Have at least twenty-five (25) Medical Center inpatient contacts per year (contact defined as an admission, observation, consultation, inpatient or outpatient procedure, or shifts worked by a hospitalist, pathologist, radiologist, or emergency physician);

OR

b. See approximately five (5) patients per week, on average, in the Medical Center ambulatory care clinics;

In the event that a Member of the Active (Voting) category does not meet the qualifications for reappointment to the Active (Voting) category, and if the Member is otherwise abiding by all Bylaws, rules, regulations, and policies of the Medical Staff and Medical Center, the Member may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives. Members of this category may:

a. Attend Medical Staff, Service, and Division meetings of which s/he is a member and any Medical Staff or Medical Center education programs;

b. Vote on all matters presented by the Medical Staff, Service, Division and committee(s) to which the member is assigned; and

c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

3.1.3 Responsibilities. Members of this category shall:

a. Contribute to the organizational and administrative affairs of the Medical Staff;

b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

c. Fulfill or comply with any applicable Medical Staff or Medical Center policies or procedures.

3.2 Courtesy (Non-Voting) Member Category

3.2.1 Qualifications. The Courtesy Member category is reserved for Members who do not meet the qualification requirements for the Active (Voting) category.

3.2.2 Prerogatives. Members of this category may:

a. Attend Medical Staff, Service, and Division meetings of which s/he is a member and any Medical Staff or Medical Center education programs;

b. Not vote on matters presented by the entire Medical Staff or be an officer of the Medical Staff, Service Chief or Division Chief; and

c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees. Unless otherwise stipulated in these Bylaws, Courtesy Members may vote on matters that come before their Service or Division that do not require a ballot.

3.2.3 Responsibilities. Members of this category shall have the same responsibilities as Active (Voting) Category Members.

3.3 Membership Only (Non-Voting) Member Category

3.3.1 Qualifications and Guidelines. Membership Only category consists of those physicians, dentists, oral surgeons, podiatrists and psychologists who:

a. Desire to be associated with, but who do not intend to establish a clinical practice at, this Medical Center; and

b. Have indicated or demonstrated a willingness to assume all the responsibilities of membership.

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

3.3.2 Prerogatives. Members of this category may:

a. Attend Medical Staff and applicable Service or Division meetings without vote and any Medical Staff or Medical Center education programs;

b. Serve as a service line executive medical director, medical director or committee chair (other than the MEC);

c. Not be an officer of the Medical Staff, Clinical Service chief or Division chief; and

d. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

3.3.3 Responsibilities. Members of this category shall fulfill or comply with any applicable Medical Staff or Medical Center policies or procedures.

3.4 Honorary Recognition

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the UTH Board. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Honorary Recognition shall be those members who have retired from active Medical Center practice, who are of outstanding reputation, and have provided distinguished service to the Medical Center. They may attend Medical Staff and Clinical Service meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote on Medical Staff or Service matters although they may vote on matters in committees to which they are assigned. Honorary Recognition does not require recredentialing.

3.5 Automatic Change in Category

Any Member of the Medical Staff that does not have any patient activity at the Medical Center or its ambulatory clinics for two (2) reappointment cycles will automatically be transferred to the Membership Only (non-voting) Member category without clinical privileges. Any such automatic transfer to the Membership Only (non-voting) Member category and corresponding expiration of clinical privileges based on inactivity is not deemed to be an adverse action based on the Member's competence or professional conduct and will not give rise to notice and hearing rights.

Section 4. Officers and Members of the Medical Staff

4.1 Officers of the Medical Staff

4.1.1 Chief of Staff

4.1.2 Vice Chief of Staff

4.1.3 Secretary

4.1.4 Immediate Past Chief of Staff

4.1.5 Two (2) Members-at-Large

4.2 Qualifications of Officers

4.2.1 Officers must be Members in good standing of the Active (Voting) category and be actively involved in patient care in the Medical Center, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the Medical Center, and have excellent administrative and communication skills. Previous leadership experience either as a Clinical Service Chief, Division Chief, or as a committee chair is preferential. The Medical Staff Nominating Committee will have discretion to determine if a Member wishing to run for office meets the qualifying criteria.

4.2.2 Officers may not simultaneously have a conflicting interest by serving on the UTH Board or MEC of another facility or organization that is directly competing with the Medical Center. Noncompliance with this requirement will result in the officer being automatically removed from office after being notified of the conflict and he/she does not deconflict within fourteen (14) days.

4.3 Election of Officers

4.3.1 The Nominating Committee is appointed by the MEC and must include no less than five (5) Active (voting) Members of the Medical Staff. Members of the MEC, including Officers of the Medical Staff, may be appointed to the Nominating Committee.

4.3.2 The Nominating Committee must nominate at least two (2) candidates for Vice Chief of Staff and Secretary. The Nominating Committee must nominate at least three (3) candidates for the two Members-at-Large. The names of the nominees will be announced at least sixty (60) days prior to the election.

4.3.3 A petition signed by at least ten (10) Active (Voting) Members may add nominations to the ballot, with written consent of the individuals being nominated. The Medical Staff must submit such a petition to the Medical Staff Office at least thirty (30) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating Committee must determine if the candidate meets the qualifications in Section 4.2 above before he/she can be placed on the ballot.

4.3.4 Ballots will be mailed or electronically transmitted to all Active (Voting) Members in a timeframe determined by the MEC. Elections shall take place by ballots cast by Active (Voting) Members returned to the Secretary by the election day noted on the ballot. The nominee(s) who receives a plurality of votes cast will be elected.

4.3.5 The Vice Chief of Staff shall automatically succeed to Chief of Staff; the Chief of Staff shall automatically succeed to Immediate Past Chief of Staff.

4.4 Term of Office

All officers, including Members-at-Large, serve a term of three (3) years. They shall take office on the July 1st following their election. An individual may not serve successive terms in the same office. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.5 Vacancies of Office

The MEC will fill vacancies of office during the Medical Staff year, except the office of the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term.

4.6 Duties of Officers

4.6.1 **Chief of Staff:** The Chief of Staff shall represent the interests of the Medical Staff to the MEC and the UTH Board and shall also report to the Medical Center CMO on matters of medical care and quality management. The Chief of Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the UTH Board and the administration of the Medical Center. The Chief of Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in these Bylaws, rules, regulations, and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the Medical Staff;

b. Serve as chair of the MEC and as ex-officio member of all other Medical Staff committees without vote, and to participate as invited by the CEO or the UTH Board on Medical Center or UTH Board committees;

c. Serve as chair of the Peer Review Committee;

d. Enforce these Bylaws, rules, regulations, and Medical Staff/Medical Center policies;

e. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with Medical Center administration, appoint Members to appropriate Medical Center committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; in consultation with the chair of the UTH Board, appoint the Members to appropriate Board committees when those are not designated by position or by specific direction of the UTH Board or otherwise prohibited by state law;

f. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;

g. Report to the UTH Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the Medical Center;

h. Continuously evaluate and periodically report to the Medical Center CMO, MEC, and the UTH Board regarding the effectiveness of the credentialing and privileging processes;

i. Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the UTH Board, Medical Center management, other professional and support staff, and the community the Medical Center serves;

j. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting Medical Center operations to Medical Center administration, the MEC, and the UTH Board;

k. Attend UTH Board meetings and UTH Board committee meetings as invited by the UTH Board;

l. Ensure that the decisions of the UTH Board are communicated and carried out within the Medical Staff;

m. Perform such other duties, and exercise such authority commensurate with the office as are set forth in these Bylaws or as requested by the Medical Center CMO; and

n. Authorize payments of Medical Staff funds in the absence of the Secretary.

4.6.2 **Vice Chief of Staff:** In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.6.3 **Secretary:** This officer will collaborate with the Medical Center's Medical Staff office, assure maintenance of minutes, attend to correspondence, act as medical staff treasurer, and coordinate communication within the medical staff. S/he shall perform such further duties to assist the Chief of Staff as may be requested from time to time.

4.6.4 **Immediate Past Chief of Staff:** This officer will serve as a consultant to the Chief of Staff and Vice Chief of Staff and provide feedback to the officers regarding their performance of assigned duties on an annual basis. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.7 Removal and Resignation from Office

4.7.1 **Removal by Vote:** Criteria for removal are failure to meet the responsibilities assigned within these Bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the Medical Center, its goals, or programs. The Medical Staff may initiate the removal of any officer if at least ten percent (10%) of the Active (Voting) Members sign a petition advocating for such action. All Active (Voting) members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed removal. The removal shall be considered approved by the Medical Staff if the removal receives two-thirds (2/3) of the votes cast by those members eligible to vote.

4.7.2 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications for being an Officer, as determined by the MEC.

4.7.3 **Resignation:** Any elected officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The Medical Staff shall be organized into Clinical Services. The Medical Staff may create Divisions within a Clinical Service in order to facilitate Medical Staff activities. A list of Clinical Services organized by the Medical Staff and formally recognized by the MEC is listed in the Organization and Functions Manual which is part of the Rules and Regulations.

5.1.2 The MEC, with approval of the UTH Board, may designate new Medical Staff Clinical Services or Divisions or dissolve current Clinical Services or Divisions as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Qualifications, Selection, Term, and Removal of Clinical Service and Division Chiefs

5.2.1 Each Clinical Service and Division will have a Chief who is 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.

5.2.2 All Clinical Service and Division Chiefs must be Active (voting) Members of the Medical Staff, have relevant clinical privileges, and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process.

5.2.3 Clinical Service and Division Chiefs are recommended to the UTH Board by the Executive Vice President for Health Affairs with the concurrence of the Chief of Staff. A Member recommended for Clinical Service or Division Chief by the above mechanism will function as the interim Chief until the UTH Board acts on the appointment.

5.2.4 A Clinical Service or Division Chief serves until a new individual is recommended for Clinical Service or Division Chief by the above mechanism.

5.2.5 Clinical Service and Division Chiefs are removed from office automatically if they fail to maintain the qualifications for the position.

5.3 Responsibilities of Clinical Service Chief

5.3.1 To oversee all clinically-related activities of the Clinical Service;

5.3.2 To oversee all administratively-related activities of the Clinical Service, unless otherwise provided by the Medical Center;

5.3.3 To provide ongoing surveillance of the performance of all individuals in the Medical Staff Service who have been granted clinical privileges;

5.3.4 To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the Medical Staff Service;

5.3.5 To recommend clinical privileges for each Member of the Clinical Service and other licensed practitioners (LPs) practicing with privileges within the scope of the Service;

5.3.6 To assess and recommend to the MEC and Medical Center administration off-site sources for needed patient care services not provided by the Clinical Service or the Medical Center;

5.3.7 To integrate the Clinical Service into the primary functions of the Medical Center;

5.3.8 To coordinate and integrate communication between and within Clinical Services;

5.3.9 To develop and implement Medical Staff and Medical Center policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;

5.3.10 To recommend the sufficient numbers of qualified and competent persons to provide care, treatment and services;

5.3.11 To provide input regarding the qualifications and competence of Clinical Service personnel who are not licensed practitioners but provide patient care, treatment, and services;

5.3.12 To continually assess and improve of the quality of care, treatment, and services;

5.3.13 To maintain quality control programs as appropriate;

5.3.14 To orient and continuously educate all persons in the Clinical Service;

5.3.15 To make recommendations for space and other resources needed by the Clinical Service to provide patient care services;

5.3.16 Be responsible for the enforcement of the mission, vision, policies, and Rules and Regulations of the Medical Center and of these Bylaws and the Policies of the Medical Staff;

5.3.17 Assist in the preparation of annual reports, including budgetary planning, pertaining to the Clinical Service as may be required by the MEC, Chief of Staff, the CMO and the UTH Board, and make recommendations for space and other resources needed by the Service; and

5.3.18 Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, the MEC, the CMO, or the UTH Board.

5.4 Responsibilities of Division Chief

Division Chiefs have the same responsibilities as the Clinical Service Chiefs as it relates to their Division. Division Chiefs report to their corresponding Clinical Service Chief.

5.5 Assignment to Service

The MEC will, after consideration of the recommendations of the Chief of the appropriate Clinical Service, recommend Clinical Service assignments for all Members in accordance with their qualifications. Each Member will be assigned to one primary Clinical Service. Clinical privileges are independent of Clinical Service assignment.

Section 6. Committees

6.1 Designation and Substitution

There is a MEC and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such Medical Center committees as are established to perform such functions. The Chief of Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee

6.2.1 Committee Membership:

a. Composition: The MEC shall be a standing committee consisting of the following Active (Voting) members: the Officers of the Medical Staff, the Clinical Service Chiefs, a Hospitalist representative, and the Credentials Committee Chair. A majority of the MEC must be physicians who are Active (Voting) Members. The chair is the Chief of Staff.

The CMO and EVP for Clinical Affairs are ex-officio members of the MEC with a vote. The CEO or their designee is an ex-officio member without a vote.

b. Designees: in the event a Clinical Service Chief is unable to attend, they may send the Deputy Clinical Service Chief as his or her designee, with a vote.

c. Removal from MEC: A Medical Staff Officer or Clinical Service Chief who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2 above will automatically lose his/her membership on the MEC.

6.2.2 Duties: The duties of the MEC, as delegated by the Medical Staff, shall be to:

a. Serve as the final decision-making body of the Medical Staff in accordance with these Bylaws and provide oversight for all Medical Staff functions;

b. Coordinate the implementation of policies adopted by the UTH Board;

c. Submit recommendations to the UTH Board concerning all matters relating to appointment, reappointment, staff category, Service assignments, clinical privileges, and corrective action;

d. Report to the UTH Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of Practitioners with privileges including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the UTH Board on medical administrative and Medical Center management matters;

g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Medical Center;

h. Participate in identifying community health needs and in setting Medical Center goals and implementing programs to meet those needs;

i. Review and act on reports from Medical Staff committees, Clinical Services, and other assigned activity groups;

j. Formulate and recommend to the Medical Staff rules, policies, and procedures;

k. Request evaluations of Practitioners privileged through the Medical Staff process when there is question about an applicant or Practitioner's ability to perform privileges requested or currently granted;

l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the Medical Center by entities outside the Medical Center;

n. Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;

o. Hold Medical Staff leaders, committees, and Services accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the Medical Staff for changes or amendments to these Bylaws;

q. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff; and

6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual general meeting of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Members via appropriate media and posted conspicuously.

7.1.2 The action of a majority of the Members present and voting at a meeting of the Medical Staff is the action of the group, except as otherwise specified in these Bylaws. Action may be taken without a meeting of the Medical Staff by presentation of the question to each Member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the Medical Staff

a. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Services

Committees and Clinical Services may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Clinical Services shall meet at least annually; committees shall meet as needed, unless otherwise stipulated in these Bylaws.

7.3 Special Meetings of Committees and Services

A special meeting of any committee, Clinical Service, or Division may be called by the committee chair or Chair or of the Clinical Service/Division thereof or by the Chief of Staff.

7.4 Quorum

7.4.1 Medical Staff Meetings: Those eligible Members present and voting on an issue.

7.4.2 MEC, Credentials Committee, and Peer Review Committee: A quorum will exist when fifty percent (50%) of the members are present.

7.4.3 Service meetings or Medical Staff committees other than those listed in 7.4.2 above: Those present and eligible Members voting on an issue.

7.5 Attendance Requirements

7.5.1 The Medical Staff attendance requirements are as follows:

a. Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

b. Special meeting attendance requirements: Whenever there is a reason to believe that a Practitioner is not complying with Medical Staff or Medical Center policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable Clinical Service Chief or Medical Staff committee chair may require the Practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given Special Notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the Practitioner's membership and/or privileges. Such termination will not give rise to a fair hearing, but will automatically be rescinded if and when the Practitioner participates in the previously referenced meeting.

c. Attendance at meetings can be done through physical presence, telephonic or electronic presence, by absentee voting, or by proxy voting. Only non-confidential matters can be done through telephonic or electronic means.

d. Nothing in the foregoing paragraph shall preclude the initiation of summary restriction or suspension of clinical privileges as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the CEO

The CEO or his/her designee may attend any general, committee, Clinical Service or Division meetings of the Medical Staff as an ex-officio member without vote.

7.7 Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Service or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Clinical Service

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Clinical Service. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only in order to break a tie.

7.10 Rights of Ex Officio Members

Except as otherwise provided in these Bylaws, persons serving as ex-officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.11 Minutes

Minutes of each regular and special meeting of a committee or Clinical Service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair, Clinical Service Chief, or designee will authenticate the minutes. A permanent file of the minutes of each meeting shall be maintained.

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the UTH Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee. The Joint Conference Committee shall consist of the four (4) Medical Staff Officers, four (4) Board representatives, and the CEO. The Joint Conference Committee will submit its recommendation to the UTH Board within thirty (30) days of its meeting.

8.1.2 To promote timely and effective communication and to foster collaboration between the UTH Board, management, and Medical Staff, the chair of the UTH Board, CEO, or the Chief of Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.1.3 Any conflict between the Medical Staff and the MEC will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of Part I of these Bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The Medical Staff is responsible for formulating and reviewing, at least triennially, any Medical Staff Bylaws, Rules and Regulations, policies, procedures, and amendments as needed. Amendments to the Bylaws or Rules and Regulations are effective when approved by the UTH Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various Sections of these Bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 Initiation by Bylaws Committee or MEC. Proposed amendments to these Bylaws may be originated by the Bylaws Committee or the MEC. When originated by the MEC, the amendment shall be sent to the Bylaws Committee for review and appropriate terminology. The amendment shall then be sent back to the MEC for approval. Once approved by the MEC, the amendment(s) will be sent to the Medical Staff for review and then for vote.

9.2.2 Initiation by the Medical Staff. Proposed amendments to these Bylaws may be originated by a petition signed by ten percent (10%) of the Active (Voting) category Members.

9.2.3 Approval Process.

a. Each Active (Voting) Member of the medical staff is eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active (Voting) Members of the medical staff shall receive at least twenty-one (21) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff unless thirty-three percent (33%) of those Members eligible to vote returns a ballot marked “no.”

b. Amendments so adopted shall be effective when approved by the UTH Board.

9.3 Methods of Adoption and Amendment to Medical Staff Rules and Regulations and Policies and Procedures

9.3.1 The Medical Staff may adopt Rules and Regulations as well as policies and procedures as necessary to carry out its functions and meet its responsibilities under these Bylaws.

9.3.2 When Rules and Regulations, or an amendment thereto, or a new or amended policy or procedure is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.

9.3.3 MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, Rules and Regulations may be adopted, amended, or repealed, in whole or in part and such changes become effective when approved by the UTH Board. Policies and procedures become effective upon approval of the MEC.

9.3.4 In addition to the process described in 9.3.2 above, the organized Medical Staff itself may recommend directly to the UTH Board an amendment(s) to the Rules and Regulations, policy or procedure by submitting a petition signed by ten percent (10%) of the Active (Voting) category Members. Upon presentation of such petition, the adoption process outlined in 9.2 above will be followed.

9.3.5 If the MEC proposes to adopt Rules and Regulations, or an amendment thereto, it must first communicate the proposal to the Medical Staff. In cases of a documented need for an urgent amendment to Rules and Regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the UTH Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If, after fifteen (15) days, there is less than a quorum of fifty percent (50%) noting disapproval of the urgent amendment, the provisional amendment stands. If there is greater than fifty percent (50%) noting disapproval of the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the UTH Board for action.

9.3.6 The MEC may adopt such amendments to these Bylaws, Rules and Regulations, policies and procedures that are, in the MEC's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and become effective when approved by the UTH Board. Neither the organized Medical Staff nor the UTH Board may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

University of Toledo Medical Center

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

Approved by the Board of Trustees – March 9, 2020
Administrative Revisions Approved – June 22, 2020
Approved by the Board of Trustees – May 24, 2023
Approved by the Board of Trustees – July 1, 2023

Table of Contents

Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Criteria for Initiation

These Bylaws encourage Medical Staff leaders and Medical Center management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and Medical Center management shall be considered confidential and part of the Medical Center's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Medical Center management. When any observations arise suggesting opportunities for a Practitioner to improve his/her clinical skills or professional behavior, the matter should be referred for peer review in accordance with the peer review, disruptive/impaired physician or performance improvement policies adopted by the Medical Staff and Medical Center. Collegial intervention efforts may include but are not limited to the following:

1.1.1 Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

1.1.2 Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged Practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

1.1.3 Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

1.2 Collegial Intervention not Effective

Following collegial intervention efforts, if it appears that the Practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the UTH Board to restrict or revoke the Practitioner's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.

Section 2. Investigations

2.1 Initiation

2.1.1 An Investigation may be initiated whenever a Practitioner with clinical privileges engages in acts or exhibits actions, statements, demeanor, or conduct that is, or is reasonably likely to be:

a. Contrary to these Bylaws, Rules and Regulations, Medical Center policies, or other applicable Medical Center or Medical Staff policies or procedures;

b. Detrimental to patient safety or to the quality or efficiency of patient care in the Medical Center;

c. Disruptive to Medical Center operations;

d. Damaging to the Medical Staff's or Medical Center's reputation;

e. Below the applicable standard of care; or

f. In violation of any law or regulation relating to federal or state health care reimbursement programs.

2.1.2 A request for an investigation must be submitted in writing by a Medical Staff officer, Medical Staff committee chair, Clinical Service Chief, CEO, CMO, or the UTH Board to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it must appropriately document its reasons. Once an investigation is initiated, the Practitioner is notified.

2.1.3 If a request for investigation is based on discriminatory behavior or sexual harassment the matter will be directed to the University's Title IX office and the investigations will run concurrently.

2.2 Investigation

If the MEC decides that an investigation is warranted, it must direct an investigation to be undertaken through the adoption of a formal resolution. In the event the UTH Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

2.2.1 **Investigating Body**. The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff. If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible.

2.2.2 **Investigation Procedure**. The committee conducting the investigation has the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC. The investigating body may also require, with the approval of the Chief of Staff and the CEO or CMO, the Practitioner under review to undergo a physical and/or mental evaluation and may access the results of such evaluations. The investigating body shall notify the Practitioner in question of the allegations that are the basis for the investigation and provide to the Practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the Practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) does not constitute a "hearing" as that term is used in the hearing and appeals Sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.3 In the event the investigation uncovers discriminatory behavior or sexual harassment, the matter will immediately be directed to the University's Title IX office and the investigations will run concurrently.

2.3 Medical Executive Committee Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

2.3.1 Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the Practitioner's file;

2.3.2 Deferring action for a reasonable time when circumstances warrant;

2.3.3 Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Clinical Service Chiefs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected Practitioner may make a written response, which shall be placed in the Practitioner's file;

2.3.4 Recommending the imposition of terms of probation or special limitation upon continued Membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, monitoring or proctoring;

2.3.5 Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

2.3.6 Recommending reductions of membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care;

2.3.7 Recommending suspension, revocation, or probation of Membership; or

2.3.8 Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends termination or restriction of the Practitioner's membership or privileges, the Practitioner is entitled to the procedural rights afforded in the Hearing and Appeal Plan of this Part II. The UTH Board shall act on the MEC's recommendation unless the member requests a hearing, in which case the final decision will be determined as set forth in the Hearing and Appeal Plan of this Part II.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following triggering circumstances, the Practitioner's privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The Chief of Staff with the approval of the CMO or CEO may reinstate the Practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty days, the Practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

3.1.1 **Licensure**

a. **Revocation and suspension:** Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Membership and clinical privileges shall be automatically relinquished by the Practitioner as of the date such action becomes effective.

b. **Restriction:** Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the Practitioner has been granted at this Medical Center that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation:** Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

3.1.2 **Medicare, Medicaid, Tricare** (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a Practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, Membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any Practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.3 **Controlled Substances**

a. **DEA Registration:** Whenever a Practitioner's United States Drug Enforcement Administration (DEA) registration is revoked, limited, or suspended, the Practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. **Probation:** Whenever a Practitioner's DEA registration is subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.4 **Medical Record Completion Requirements:** A Practitioner will be considered to have his/her privilege to admit new patients or schedule new elective procedures voluntarily suspended whenever s/he fails to complete medical records within time frames established by the MEC. This suspension of privileges shall not apply to patients admitted or already scheduled at the time of suspension, to emergency patients, or to imminent deliveries. The suspended privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.5 **Professional Liability Insurance:** Failure of a Practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and UTH Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic suspension of a Practitioner's clinical privileges. If within 60 calendar days of the suspension the Practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the Practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The Practitioner must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.6 **Medical Staff Dues/Special Assessments:** Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic suspension of a Practitioner's appointment. If within 60 calendar days after written warning of the delinquency the Practitioner does not remit such payments, the Practitioner shall be considered to have voluntarily resigned membership on the Medical Staff.

3.1.7 **Felony Conviction:** A Practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony in any jurisdiction shall automatically relinquish Membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the UTH Board or through corrective action, if necessary. This does not preclude the MEC from taking action on charges or indictments of the above offenses.

3.1.8 **Failure to Satisfy the Special Appearance Requirement:** A Practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these Bylaws shall be considered to have all clinical privileges, with the exception of emergencies and imminent deliveries, automatically suspended. These privileges will be restored when the Practitioner complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.9 **Failure to Participate in Required Testing:** A Practitioner who fails to participate in required testing, as noted in Part I, Section 2.6.4, and authorizes release of this information to the MEC, shall be considered to have all privileges automatically suspended. These privileges will be restored when the Practitioner complies with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.10 **Failure to Become Board Certified or Maintain Board Certification:** A Practitioner who fails to become board certified in compliance with these Bylaws as noted in Part III, Section 2.2 or Medical Staff credentialing policies will be deemed to have voluntarily relinquished his or her Medical Staff appointment and clinical privileges, becoming effective at the next reappointment date. A grace period of up to two (2) years to become recertified may be granted by the MEC upon an appropriate justification. A Practitioner who fails to be recertified in compliance with these Bylaws or medical staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges.

3.1.11 **Failure to Execute Release and/or Provide Documents:** A Practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the Chief of Staff or designee to evaluate the competency and credentialing/privileging qualifications of the Practitioner shall be considered to have all privileges automatically suspended. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic suspension, the Practitioner may be reinstated. After thirty (30) calendar days, the Member will be deemed to have resigned voluntarily from the staff and must reapply for Membership and privileges.

3.1.12 **Medical Executive Committee Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these Bylaws.

3.2 Summary Restriction or Suspension

3.2.1 **Criteria for Initiation:** A summary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to (1) protect the life or well-being of patient(s), (2) reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person, or (3) when Medical Staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient or employee safety or the effective operation of the Medical Center. Under such circumstances one (1) Medical Staff leader (such as a Medical Staff Officer or Clinical Service Chief) in conjunction with one (1) administrator (such as CEO or CMO) shall restrict or suspend the Membership or clinical privileges of such Practitioner as a precaution. A suspension of all or any portion of a Practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the Practitioner's clinical privileges at this Medical Center.

Unless otherwise stated, such summary restriction or suspension will become effective immediately upon imposition and the person or body responsible will promptly give written notice to the Practitioner, the MEC, the CEO, and the UTH Board. The restriction or suspension may be limited in duration and will remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patients will be promptly assigned to another Member by the Chief of Staff or designee, considering, where feasible, the wishes of the affected Practitioner and the patient in the choice of a substitute Practitioner.

3.2.2 **Medical Executive Committee Action:** As soon as feasible and within fourteen (14) calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the Practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event will any meeting of the MEC, with or without the Practitioner, constitute a "hearing" as defined in the Hearing and Appeal Plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the Practitioner with notice of its decision.

3.2.3 **Procedural Rights:** Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member or other physician or dentist with privileges without membership (or applicant for the above) shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any Practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership are entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the UTH Board. Hearings are triggered only by the following "adverse actions" when the basis for such action is related to clinical competence or professional conduct:

4.1.1 Denial of Medical Staff appointment or reappointment;

4.1.2 Revocation of Medical Staff appointment;

4.1.3 Denial or restriction of requested clinical privileges, but only if such action is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;

4.1.4 Involuntary reduction or revocation of clinical privileges;

4.1.5 Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Member and is imposed for more than fourteen (14) calendar days; or

4.1.6 Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions:

4.2.1 Issuance of a letter of guidance, warning, or reprimand;

4.2.2 Imposition of a requirement for proctoring (i.e., observation of the Practitioner's performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges;

4.2.3 Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

4.2.4 Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

4.2.5 Requirement to appear for a special meeting under the provisions of these Bylaws;

4.2.6 Automatic relinquishment or voluntary resignation of appointment or privileges;

4.2.7 Imposition of a summary suspension that does not exceed fourteen (14) calendar days;

4.2.8 Denial of a request for leave of absence, or for an extension of a leave;

4.2.9 Determination that an application is incomplete or untimely;

4.2.10 Determination that an application will not be processed due to misstatement or omission;

4.2.11 Decision not to expedite an application;

4.2.12 Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

4.2.13 Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

4.2.14 Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;

4.2.15 Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

4.2.16 Termination of any contract with or employment by Medical Center;

4.2.17 Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;

4.2.18 Any recommendation voluntarily accepted by the Practitioner;

4.2.19 Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

4.2.20 Change in assigned staff category;

4.2.21 Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

4.2.22 Removal or limitations of emergency department call obligations;

4.2.23 Any requirement to complete an educational assessment;

4.2.24 Retrospective chart review;

4.2.25 Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws;

4.2.26 Grant of conditional appointment or appointment for a limited duration; or

4.2.27 Appointment or reappointment for duration of less than 36 months.

4.3 Notice of Recommendation of Adverse Action

When a summary suspension lasts more than fourteen (14) calendar days or when an Adverse Action is recommended by the MEC, which, according to this Hearing and Appeal Plan entitles an individual to request a hearing prior to a final decision of the UTH Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the CEO, or designee, delivered either in person or by certified mail, return receipt requested. This notice shall contain:

4.3.1 A statement of the recommendation made and the general reasons for it (Statement of Reasons);

4.3.2 Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;

4.3.3 Notice that the recommendation, if finally adopted by the UTH Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

4.3.4 The individual shall receive a copy of Part II of these Bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

A Practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the CEO or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final UTH Board action.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the Practitioner's timely request for a hearing, the CEO shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

4.5.1 The time, place, and date of the hearing;

4.5.2 A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the UTH Board), at the hearing;

4.5.3 The names of the hearing panel members and presiding officer or hearing officer, if known; and

4.5.4 A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

5.1.1 When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. This panel will be appointed by the CEO, or designee, in conjunction with the Chief of Staff. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the Medical Center or an affiliate will not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the Medical Center Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

5.1.2 The hearing panel shall not include any individual who is in direct economic competition with the affected Practitioner or any such individual who is in professional practice with or related to the affected Practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

5.1.3 The CEO or designee shall notify the Practitioner requesting the hearing of the names of the panel members and the date by which the Practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the CEO. The CEO shall determine whether a replacement panel member should be identified. Although the Practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CEO.

5.2 Hearing Panel Chairperson or Presiding Officer

5.2.1 In lieu of a hearing panel chair, the CEO, acting for the UTH Board and after considering the recommendations of the Chief of Staff (or those of the chair of the UTH Board, if the hearing is occasioned by a UTH Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no previous relationship with either the Medical Center, organized Medical Staff, or the Practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the CEO to serve as the presiding officer and shall be entitled to one vote.

5.2.3 The presiding officer (or hearing panel chair) shall do the following:

a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and

h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the Medical Center may advise the presiding officer or panel chair.

5.3 Hearing Officer

5.3.1 As an alternative to the hearing panel described above, the CEO, acting for the UTH Board and in conjunction with the Chief of Staff (or those of the chair of the UTH Board, if the hearing is occasioned by a UTH Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.

5.3.2 The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the "hearing panel" or "presiding officer" are deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal "discovery" in connection with the hearing and the rules of evidence do not apply. The presiding officer, hearing panel chair, or hearing officer will rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing is entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents are maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and are not disclosed or used for any purpose outside of the hearing:

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

b. Reports of experts relied upon by the MEC or UTH Board;

c. Copies of redacted relevant committee minutes;

d. Copies of any other documents relied upon by the MEC or the UTH Board;

e. No information regarding other Practitioners shall be requested, provided, or considered; and

f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

6.1.2 Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known must be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

6.1.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the Medical Center's witness list concerning the subject matter of the hearing; nor shall there be contact by the Medical Center's with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the UTH Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the UTH Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing

The hearing panel will maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter is borne by the Medical Center, but copies of the transcript will be provided to the individual requesting the hearing at that individual's expense. The hearing panel may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the state of Ohio.

6.5 Rights of the Practitioner and the Medical Center

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To call and examine witnesses to the extent available;

b. To introduce exhibits;

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may argue the case for his/her client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;

e. To submit a written statement at the close of the hearing.

6.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

6.5.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed with ten (10) business days, following the close of the hearing.

6.8 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.9 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer or the CEO on a showing of good cause.

6.10 Persons to be Present

The hearing is restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or CEO. All members of the hearing panel shall be present, absent good cause, for all stages of the hearing and deliberations.

6.11 Order of Presentation

The UTH Board or the MEC, depending on whose recommendation prompted the hearing initially, will first present evidence in support of its recommendation. Thereafter, the burden shifts to the individual who requested the hearing to present evidence.

6.12 Basis of Recommendation

The hearing panel will recommend in favor of the MEC (or the UTH Board) unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

6.13 Adjournment and Conclusion

The presiding officer may recess the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing is closed.

6.14 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel will conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and render a recommendation, accompanied by a report, signed by all the panel members, which will contain a concise statement of the reasons for the recommendation.

6.15 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the CEO who shall forward it, along with all supporting documentation, to the UTH Board for further action. The CEO shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment. If the hearing panel report confirms the original adverse recommendation, the Practitioner has the right to appellate review as outlined below. If the hearing panel report differs from the original MEC or UTH Board recommendation, the MEC or UTH Board may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the affected Practitioner, including a statement of the basis for its recommendation. Upon receipt of the recommendation by the UTH Board or MEC, the affected Practitioner has the right to appellate review as outlined below.

Section 7. Appeal to the UTH Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, or after the MEC or UTH Board makes its final recommendation, either the Practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing, and must be delivered to the CEO or designee either in person or by certified mail, and include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties are deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation are forwarded to the UTH Board.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

7.2.1 There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or

7.2.2 The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or

7.2.3 The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

Whenever an appeal is requested as set forth in these Bylaws, the chair of the UTH Board will schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual will be given notice of the time, place, and date of the appellate review. The chair of the UTH Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

7.4.1 The chair of the UTH Board shall appoint a review panel composed of at least three (3) members of the UTH Board to consider the information upon which the recommendation before the UTH Board was made. Members of this review panel may not be direct competitors of the Practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

7.4.2 The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter is borne by the Medical Center, but copies of the transcript will be provided to the individual requesting the review at that individual's expense. The review panel may, but is not required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Ohio.

7.4.3 Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the UTH Board.

7.4.4 The UTH Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the UTH Board's ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the UTH Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the UTH Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or Member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the UTH Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this Medical Center unless the UTH Board advises otherwise.

7.7 Fair Hearing and Appeal for Those with Privileges Without Membership and Who are Not Physicians or Dentist

It is noted that if the Practitioner is to be voluntarily reported to the NPDB, the Practitioner must have the full fair hearing and appeal process as noted above, instead of the simplified version below.

Physician assistants (PAs), Advanced Practice Registered Nurses (APRNs), surgical assistants, and registered nurse first assistants (RNFAs) and other Allied Health Practitioners are not entitled to the hearing and appeals procedures set forth in these Bylaws.

7.7.1 In the event one of these Practitioners receives notice of a recommendation by the MEC that adversely affects his/her exercise of clinical privileges, the Practitioner and his/her supervising physician, if applicable, have the right to meet personally with two physicians and a peer assigned by the Chief of Staff to discuss the recommendation. The Practitioner and the supervising physician must request such a meeting in writing to the CEO within ten (10) calendar days from the date of receipt of the notice of adverse recommendation. At the meeting, the Practitioner and the supervising physician, or designee alternates, must be present to discuss, explain, or refute the recommendation, but such meeting will not constitute a hearing and none of the procedural rules set forth in these Bylaws with respect to hearings apply. Findings from this review body will be forwarded to the affected Practitioner, the MEC and the UTH Board.

7.7.2 The Practitioner and the supervising physician may request an appeal in writing to the CEO within 10 days of receipt of the findings of the review body. Two members of the UTH Board assigned by the chair of the UTH Board will hear the appeal from the Practitioner and the supervising physician. A representative from the Medical Staff leadership may be present. The decision of the appeal body will be forwarded to the UTH Board for final decision. The Practitioner and the supervising physician will be notified within ten (10) calendar days of the final decision of the UTH Board.

University of Toledo Medical Center

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

Approved by the Board of Trustees – March 9, 2020
Administrative Revisions Approved – June 22, 2020
Approved by the Board of Trustees – May 24, 2023
Approved by the Board of Trustees – July 1, 2023

Table of Contents

Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the Medical Staff Credentials Committee shall consist of Members of the Active (Voting) Medical Staff selected by the Chief of Staff on a basis that will ensure representation of the major clinical specialties and the Medical Staff At-Large. A representative of the APPs will be appointed to the committee but will vote only on the applications of other APPs. Three members of Legal Affairs and Risk Management will be ex-officio members of the committee without vote.

Members will be appointed for staggered three (3) year terms and members may be reappointed for additional terms without limit. The committee may also invite members such as representatives from Medical Center administration and the UTH Board.

1.2 Meeting

The Medical Staff Credentials Committee will meet at least ten (10) times per year and on call of the Credentials Committee Chair or Chief of Staff.

1.3 Responsibilities

1.3.1 To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

1.3.2 To review and recommend action on all requests regarding privileges from eligible Practitioners;

1.3.3 To recommend eligibility criteria for the granting of Membership and privileges;

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

1.3.5 To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff or Medical Center leaders; and

1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.4.1 The credentials file is the property of the Medical Center and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the Medical Center in locked file cabinets or in secure electronic format. Medical Staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the CEO or designee.

1.4.2 Individual Practitioners may review their credentials file under the following circumstances:

1.4.3 Only upon request approved by the Chief of Staff, CEO, credentials committee chair or CMO. Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of

reference may not be reviewed by Practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a Practitioner. Nothing may be removed from the file. Only items supplied by the Practitioner or directly addressed to the Practitioner may be copied and given to the Practitioner. The Practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review

Section 2. Qualifications for Membership and/or Privileges

2.1 No Practitioner is entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization

2.2 The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or clinical privileges:

2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.2 Have a current state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Ohio. The license must be unrestricted for initial appointment;

2.2.3 Have a record that is free from current Medicare, Medicaid and TriCare sanctions and not be on the OIG List of Excluded Individuals/Entities;

2.2.4 Have a record that shows the applicant has never been (1) convicted of, or entered a plea of guilty or no contest to a felony, (2) convicted (as that term is defined under 42 USC 1320a-7(i)) of a criminal offense related to health care, (3) or subject of a final adverse action as the such term is defined under 42 USC 1320a-7e(g);

2.2.5 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or any foreign board acknowledged by the American board;

2.2.6 A physician applicant, MD or DO, must be currently board certified or become board certified in the specialty in which the applicant will primarily practice and is requesting privileges within five (5) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association, or any foreign board acknowledged by the American board;

2.2.7 A physician applicant, MD or DO, who is a foreign medical graduate and who is a UT faculty member using the alternative pathway, must be currently board certified or become board certified in the specialty in which the applicant will primarily practice and is requesting privileges within seven (7) years of initial grant of privileges at UTMC;

2.2.8 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.9 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery, or any foreign board acknowledged by the American board;

2.2.10 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine;

2.2.11 A psychologist must have an earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate by the American Board of Professional Psychology to the area of clinical practice;

2.2.12 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either is required for initial applicants or be actively seeking initial certification and obtain the same on the first examination for which eligible and reapplicants.

2.2.13 An anesthesia assistant must have successfully completed a graduate level degree program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or any of the commission's successor organizations, which qualifies the candidate to sit for the National Commission for Certification of Anesthesiologist Assistants (NCCAA) examination. Current certification by the National Commission for the Certification of Anesthesiologist Assistants (NCCAA) as an Anesthesiologist Assistant-Certified (AA-C) is required for initial applicants and reapplicants.

2.2.14 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the American Midwifery Certification Board (AMCB), or be actively seeking initial certification and obtain the same on the first examination for which eligible is required for initial applicants and reapplicants.

2.2.15 A nurse practitioner (NP) or clinical nurse specialist (CNS) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner or clinical nurse specialist program accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Academy of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC) or the American Association of Critical Care Nurses (AACN) or an equivalent body is required for initial applicants or be actively seeking certification and obtain the same on the first examination for which he/she is eligible and reapplicants.

2.2.16 A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C is required for initial applicants and reapplicants.

2.2.17 A registered nurse first assistant (RNFA) must have successfully completed an approved AORN RNFA training program that meets the AORN standards for RN first assistant education programs. Current certification in perioperative nursing (CNOR) by the Association of Operating Room Nurses (AORN) and current RNFA certification or active participation in the certification process to be achieved within 9 months of eligibility is required for initial applicants. Current certification is required for reapplicants.

2.2.18 Surgical First Assistant must be in compliance with one of the following pathways:

a. Certified Surgical Technician and certification as a Surgical First Assistant, or

b. Certified Surgical Technician and meets the requirements for acceptance in a surgical assistant certification program. Certification must be completed within three (3) years of granting of privileges.

2.2.19 Medical physicists must hold a bachelor's degree in physics or applied physics from an approved institution; or a bachelor's degree from an accredited institution in an appropriate engineering (e.g., electrical, mechanical, biomedical or nuclear), chemistry, physical chemistry, or applied mathematics with a minor in physics. They must hold a masters or doctoral degree from an institution accredited by a regional accrediting body, in medical physics or physics; or in another physical science, applied mathematics, or engineering. They must be board certified, or be board eligible, by the American Board of Radiology or the American Board of Medical Physics. Board certification must occur within five (5) years of the completion of training.

2.2.20 PhD exercise physiologists must possess an advanced degree (Masters or Doctoral) in Exercise Physiology.

2.2.21 Pharmacists must have successfully completed a Bachelor of Science in Pharmacy or Doctor of Pharmacy degree, have documentation of current BLS or ACLS certification, and be licensed as a Registered Pharmacist in the State of Ohio.

2.2.22 Registered dieticians must have completed a baccalaureate or higher degree from a US regionally accredited university or college and course work accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics. They must have successfully completed ACEND-accredited supervised practice program. They must be currently registered as a Dietitian by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics and have maintained at least seventy-five (75) hours of continuing education every five (5) years per requirements. They must also possess a license to practicce dietetics by the Ohio Board of Dietetics.

2.2.23 Licensed Independent Social Workers must have successfully completed a masters or doctoral degree in social work from an accredited educational institution, have two (2) years (three thousand (3000) hours) of social work experience obtained after grant of the graduate degree under the supervision of an Independent Social Worker, and have passed the State of Ohio "advanced" or "clinical" examination.

2.2.24 Audiologists must have successful completion of a doctor of audiology degree, or the equivalent, and possess a license as an Audiologist in the State of Ohio.

2.2.25 Have appropriate written and verbal communication skills;

2.2.26 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

b. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

2.3 In Addition to Privilege-Specific Criteria, the Following Qualifications Must Also be Met and Maintained by All Applicants Requesting Clinical Privileges:

2.3.1 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

2.3.2 Possess current and valid Ohio DEA registration number if applicable. The Ohio DEA registration must be unrestricted for initial appointment;

2.3.3 Possess a valid NPI number;

2.3.4 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Membership and/or the specific privileges requested by and granted to the applicant;

2.3.5 Any Practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and UTH Board;

2.3.6 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

2.3.7 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the Medical Center. There must also be a need for this service under any UTH Board approved Medical Staff development plan;

2.3.8 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the UTH Board after consultation with the MEC.

2.4 Exceptions

2.4.1 Only the UTH Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence that a Practitioner demonstrates an equivalent competence in the areas of the requested privileges.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant an application package, which will include a complete set or overview of the Medical Staff Bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Membership and/or privileges and a list of expectations of performance for individuals granted Membership or privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, at a minimum:

a. A completed, signed, dated application form;

b. A completed privilege delineation form if requesting privileges;

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;

d. All applicable fees;

e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture Medical Center ID card;

f. Receipt of at least three (3) references; references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. At least one reference must be from someone in the same professional discipline;

g. Relevant practitioner-specific data as compared to aggregate data, when available; and

h. Morbidity and mortality data, when available.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff Office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of Medical Center, that the applicant meets the requirements for Membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter or email requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within twenty-one (21) calendar days of the receipt of the request letter or email, the application will be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application the CMO or Credentials Committee chair, in collaboration with the Medical Staff office, will determine if the requirements of Sections 2.2 and 2.3 are met. In the event the requirements of Sections 2.2 and 2.3 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of Sections 2.2 and 2.3 are met, the application will be accepted for further processing.

3.1.4 Individuals seeking appointment shall have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

3.1.5 Upon receipt of a completed application, the Medical Staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the Medical Staff office will collect relevant additional information which may include:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any) during the past five (5) years;

b. Verification of the applicant's past clinical work experience;

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

d. Information from the AMA or AOA Physician Profile and OIG list of Excluded Individuals/Entities or SAM (System for Award Management);

e. Information from professional training programs (verification from professional degree forward) including residency and fellowship programs;

f. Information from the National Practitioner Data Bank (NPDB); in addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

g. Other information about adverse credentialing and privileging decisions;

h. Receipt of three (3) peer recommendations, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;

i. Information from a criminal background check, covering at a minimum the past seven (7) years, for initial application only;

j. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges;

k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available; and

l. Verify that the applicant requesting approval is the same individuals identified in the credentialing document by viewing (i) a current picture hospital ID card or (ii) a valid picture ID issued by a state or federal agency (e.g. driver's license or passport).

Note: In the event there is undue delay in obtaining required information, the Medical Staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after twenty-one (21) calendar days will be deemed a withdrawal of the application.

3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization, and Acknowledgement

The applicant must complete and sign the application form. By signing this application, the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any substantive inaccuracy, omission, or misrepresentation may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges will lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

3.2.2 Consents to appear for any requested interviews in regard to his/her application.

3.2.3 Authorizes the Medical Center and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consents to Medical Center and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested;

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

c. Professional and ethical qualifications;

d. Professional liability actions including currently pending claims involving the applicant; and

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the Medical Center or the Medical Staff, including otherwise privileged or confidential information to the Medical Center representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

3.2.6 Authorizes the Medical Center Medical Staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any Medical Staff or Medical Center representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

3.2.7 Acknowledges that the applicant has had access to the Medical Staff Bylaws, including all rules, regulations, policies and procedures of the Medical Staff, and agrees to abide by their provisions.

3.2.8 Agrees to provide accurate answers to the questions on the Medical Staff application form, and agrees to immediately notify the Medical Center in writing if any of the information regarding the application form questions change during processing of the application or the period of the applicant's Membership or privileges. If the applicant answers any of the questions affirmatively and/or provides information identifying a problem with any of the questions, the applicant is required to submit a written explanation of the circumstances involved.

3.3 Application Evaluation

3.3.1 Applicant Interview

a. All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Clinical Service Chief, Credentials Committee, MEC, or UTH Board. The interview may take place in person or by telephone at the discretion of the Medical Center or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.

b. Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview within forty-five (45) days of completion of his or her application will be deemed a withdrawal of the application.

3.3.2 Service Chief Action

a. All completed applications are presented to the Service Chief or designee for review, and recommendation. The Service Chief reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Clinical Service Chief may obtain input if necessary from an appropriate subject matter expert. If a Clinical Service Chief believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment.

b. The Clinical Service Chief forwards to the Medical Staff Credentials Committee the following:

   i. A recommendation as to whether to (1) approve the applicant's request to membership and/or privileges, (2) to approve membership but modify the requested privileges or (3) deny membership and/or privileges;

   ii. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and

   iii. Comments to support these recommendations.

3.3.3 Medical Staff Credentials Committee Action

The Medical Staff Credentials Committee reviews the application and forwards the following to the MEC:

a. A recommendation to (1) approve the applicant's request for membership and/or privileges, (2) to approve membership but modify the requested privileges or (3) deny membership and/or privileges;

b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and

c. Comments to support these recommendations.

3.3.4 Medical Executive Committee Action

The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the UTH Board:

a. A recommendation to (1) approve the applicant's request for membership and/or privileges, (2) to approve membership but modify the requested privileges or (3) deny membership and/or privileges;

b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and

c. Comments to support these recommendations.

Whenever the MEC makes an adverse recommendation to the UTH Board, a Special Notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.5 **UTH Board Action:**

The UTH Board reviews the application and votes for one of the following actions:

a. If the UTH Board agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed thirty-six (36) months.

b. If the UTH Board disagrees with the recommendation, then the UTH Board votes for one of the following actions:

   i. The UTH Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the UTH Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed thirty-six (36) months;

   ii. If the UTH Board's action is adverse to the applicant, a Special Notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

   iii. The UTH Board shall take final action in the matter as provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.6 **Notice of Final Decision:** Notice of the UTH Board's final decision shall be given, through the CEO to the MEC and to the Chair of each Clinical Service concerned. The applicant shall receive written notice of appointment and Special Notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Service to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.3.7 **Time Periods for Processing:** All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 90 (ninety) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Reappointment

4.1 Criteria for Reappointment

It is the policy of the Medical Center to approve for reappointment and/or renewal of privileges only those Practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine that the Practitioner provides effective care that is consistent with the Medical Center standards regarding ongoing quality and the Medical Center performance improvement program. The Practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed thirty-six (36) months. The granting of new clinical privileges to existing Members or other Practitioners with privileges will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 6.1 below concerning focused professional practice evaluation. A suitable peer shall substitute for the Service Chief in the evaluation of current competency of the Service Chief, and recommend appropriate action to the Credentials Committee.

4.2 Information Collection and Verification

4.2.1 **From appointee:** On or before ninety (90) days prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the Practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least seventy-five (75) days prior to the date of expiration of a Medical Staff appointment or grant of privileges, the Practitioner must return the following to the Medical Staff office:

a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;

b. Information concerning continuing training and education internal and external to the Medical Center during the preceding period; and

c. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

4.2.2 From internal and/or external sources: The Medical Staff office collects and verifies information regarding each Practitioner's professional and collegial activities to include those items listed on the Medical Staff application form.

4.2.3 The following information is also collected and verified:

a. A summary of clinical activity at this Medical Center for each Practitioner due for reappointment;

b. Performance and conduct in this Medical Center and other healthcare organizations in which the Practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

c. Documentation of educational modules, as required or applicable;

d. Timely and accurate completion of medical records;

e. Compliance with all applicable Bylaws, policies, rules, regulations, and procedures of the Medical Center and Medical Staff;

f. Any significant gaps in employment or practice since the previous appointment or reappointment;

g. Verification of current licensure;

h. National Practitioner Data Bank query, information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management) and FSMB (Federation of State Medical Boards);

i. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges; and

j. Malpractice history for the past three (3) years, which is primary source verified by the Medical Staff office with the Practitioner's malpractice carrier(s).

4.2.4 Failure, without good cause, to provide any requested information, at least seventy-five (75) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff office verifies this additional information and notifies the Practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.3 Evaluation of Application for Reappointment of Membership and/or Privileges

4.3.1 The reappointment application will be reviewed and acted upon as described in Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an "adverse recommendation" by the UTH Board as used in Section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the Medical Staff Bylaws. The terms "applicant" and "appointment" as used in these Sections shall be read respectively, as "staff appointee" and "reappointment."

Section 5. Clinical Privileges

5.1 Exercise of Privileges

A Practitioner providing clinical services at the Medical Center may exercise only those privileges granted to him/her by the UTH Board or emergency or disaster privileges as described herein. Privileges may be granted by the UTH Board, upon recommendation of the MEC to Practitioners who are not members of the Medical Staff. Such individuals may be Advanced Practice Providers, physicians serving short locum tenens positions, telemedicine physicians, or house staff such as fellows moonlighting in the Medical Center, or Allied Health Professionals (AHPs) such as registered nurse first assistants (RNFAs) or surgical assistants who perform a surgical level of care, or others deemed appropriate by the MEC and UTH Board.

5.2 Requests

When applicable, each application for appointment or reappointment to the Medical Staff or for privileges must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

5.3 Basis for Privileges Determination

5.3.1 Requests for clinical privileges are only considered when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Medical Center in its UTH Board approved criteria for clinical privileges.

5.3.2 Privileges for which no criteria have been established:

All requests for a privilege for a new technology, a procedure new to the Medical Center, an existing procedure used in a significantly different manner, or a procedure involving a cross-specialty privilege for which no criteria have been established must be submitted by the requesting Member to the Clinical Service Chief and the Chair of the Credentials Committee. The Clinical Service Chief, Credentials Committee and the requesting Member will follow the process outlined below as a guideline as to whether or not the new privilege and approving criteria should be developed:

a. The first stage of the new privilege process is to determine if the procedure will be permitted by the Medical Center. The requirements for this step are:

   i. Ensure that the new privilege is consistent with the Medical Center's mission, values, strategic, and operating plans.

   ii. The equipment is available, will be purchased, or another acceptable arrangement to obtain the equipment has been agreed to by the Medical Center

   iii. Appropriate nursing and other support staff are available and have the necessary competencies, or that appropriate training or in servicing has been arranged.

   iv. Sufficient space is available or will be made available within a specified time frame.

   v. Sufficient financial resources are available or will be made available within a specified time frame.

b. If the requirements outlined in 5.3.2(a) above have not been met the process of developing new privileging criteria may proceed. However, the new privilege will not be recommended by the Credentials Committee to the MEC until the requirements have been satisfied.

5.3.3 Developing New Privileging Criteria:

a. The Credentials Committee will determine which specialties will be involved with the performance of the new procedure. The requesting Members along with representatives from any other involved specialties will be requested to develop proposed credentialing criteria.

b. The criteria must consider and/or include:

i. Basic education and training required;

ii. What specific residency, fellowship or subsequent course training may be required;

iii. Whether two or more "tracks" for privileging are appropriate. (Recent residency training may be sufficient if the procedure is now routinely taught during residency, but for those not trained recently, a special course may be required);

iv. What prior experience is required;

v. Proctoring requirements and how they may be implemented;

vi. Whether training requirements will differ for different specialties; and

vii. Any relevant literature or professional society consensus statements regarding the procedure. These may be used as a resource for developing credentialing criteria.

c. The proposed criteria is then submitted to the Credentials Committee for review and recommendation.

i. Upon review, the Credentials Committee may request more information from the submitting Members, the input of additional departments, or additional information from Nursing or other Medical Center departments.

ii. The Credentials Committee should discuss the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the Medical Center by appropriate regulatory agencies (FDA, OSHA, etc.);

d. The recommendation of the Credentials Committee will be transmitted to the MEC.

i. The MEC will then recommend approval, further refinement, or disapproval.

ii. If approval is recommended, the criteria shall be forwarded to the UTH Board for final action. If disapproval or further refinement is recommended the proposed criteria will be sent back to the Credentials Committee

e. A Member may submit his or her request for privileges at the same time as the criteria are being considered but such request can only be acted upon following the positive recommendation and approval of the criteria. In such a case, it would of course be expected that the applicant(s) meet the requirements of the criteria that are eventually approved.

5.4 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.

5.5 Special Conditions for Practitioners Eligible for Privileges Without Membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for Membership, with the exception that such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the UTH Board for providing services at the Medical Center are eligible to apply for privileges. Practitioners with privileges must pay Medical Staff dues in an amount set by the Medical Staff Office that will not exceed the amount paid by Members. Advance Practice Professionals (APPs) such as Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. Allied Health Professionals (AHPs) such as surgical assistants and Registered Nurse First Assistants (RNFAs) in this category may not exercise independent judgment and work under the direct supervision of a physician who has been accorded privileges to provide such care. The privileges of these APPs and AHPs shall terminate immediately, without right to due process, in the event the employment contract or sponsorship of the APP or AHP with a physician Member of the Medical Staff organization is terminated for any reason.

5.6 Special Conditions for Residents or Fellows in Training

5.6.1 Residents or fellows in training in the Medical Center shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the DIO in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and Medical Center leaders.

5.6.2 The DIO must communicate periodically with the MEC and the UTH Board about the performance of residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

5.6.3 Fellows in training may apply for privileges at the Medical Center in the area of their completed residency program. Fellows must meet all of the qualifications for Membership in Part III, Section 2 of these Bylaws. If granted privileges it is without Membership in the Medical Staff.

5.7 Telemedicine Privileges

5.7.1 Requests for telemedicine privileges at the Medical Center that includes patient care, treatment, and services will be processed through one of the following mechanisms:

a. The Medical Center privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization; or

b. The Medical Center uses the credentialing and privileging decision from the distant site if all of 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 those services to be provided at this Medical Center; and

iii. The Medical Center has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed practitioner from patients, licensed practitioners, or staff at the Medical Center.

5.8 Temporary Privileges

The CEO, or designee, acting on behalf of the UTH Board and based on the recommendation of the Chief of Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: (1) to fulfill an important patient care, treatment, or service need, or (2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the UTH Board.

5.8.1 Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff verifies current licensure, current competence, current malpractice insurance ($1M/$3M), NPDB, Ohio DEA, Board Certification, OIG, and SAMS .

5.8.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Membership and/or privileges is waiting for review and recommendation by the MEC and approval by the UTH Board. Criteria for granting temporary privileges in these circumstances include (1) complete application (2) fully verified application, (3) positive recommendation from the Service Chief, (4) positive recommendation from the Credentials Committee (5) no current or previously successful challenge to applicant's licensure or registration, (6) no involuntary termination of applicant's medical staff membership at any organization and (7) no involuntary limitation, reduction, denial or loss of applicant's clinical privileges at any organization.

5.8.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by these Bylaws, rules, and regulations and policies of the Medical Staff and Medical Center in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

5.8.4 Termination of temporary privileges: The CEO, acting on behalf of the UTH Board and after consultation with the Chief of Staff, may terminate any or all of the Practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose a summary suspension under the Medical Staff Bylaws may execute the termination. In the event of any such termination, the Practitioner's patients then will be assigned to another Practitioner by the Chief of Staff or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

5.8.5 Rights of the Practitioner with temporary privileges: A Practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.9 Emergency Privileges: In the case of a medical emergency, any Practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Practitioner's license, regardless of Clinical Service affiliation, staff category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.10 Disaster Privileges:

5.10.1 If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

a. A current picture hospital ID card that clearly identifies professional designation;

b. A current license to practice;

c. Primary source verification of the license;

d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

f. Identification by a current hospital or Member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed practitioner during a disaster.

5.10.2 The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

5.10.3 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

5.10.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: (1) why primary source verification could not be performed in 72 hours; (2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and (3) an attempt to rectify the situation as soon as possible.

5.10.5 Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

5.10.6 Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Medical Center and will not give rise to a right to a fair hearing or an appeal.

Section 6. Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of FPPE. The Credentials Committee, after receiving a recommendation from the Service Chief and with the approval of the MEC, will define the circumstances which require monitoring and evaluation of the clinical performance of each Practitioner following his or her initial grant of clinical privileges at the Medical Center. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

The Medical Staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of Practitioner's current clinical competency. In addition, each Practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

6.3 Re-Entry for Practitioners

6.3.1 A practitioner who has not provided care within the past two (2) years who requests clinical privileges at the Medical Center must complete a formal process to assess and confirm clinical competence as determined by the Service Chief, Credentials Committee, and MEC.

6.3.2 If a practitioner has not practiced within the past two (2) years, but has practiced within the past five (5) years, then a formal precepting program at the Medical Center must be completed prior to the grant of independent privileges. A description of the preceptorship, including details of monitoring and consultation must be written and submitted for approval to the Service Chief, Credentials Committee and MEC. At a minimum, the preceptorship or training program description must include the following:

a. The scope and intensity of the required activities;

b. The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

6.3.3 If the practitioner has not practiced within the past five (5) years, then the practitioner must complete a formal re-entry process through an accredited program. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. If additional formal training is required, a description of the training program, must be written and submitted for approval to the Service Chief, Credentials Committee, and MEC.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or UTH Board, a Practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the Practitioner must submit such additional information as the Medical Staff and/or UTH Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for Modification of Appointment Status or Privileges

A Practitioner, either in connection with reappointment or at any other time, may request modification of staff category, Clinical Service assignment, or clinical privileges by submitting a written request to the Medical Staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A Practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the Medical Staff office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the Practitioner's credentials file.

7.3 Resignation of Staff Appointment or Privileges

A Practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate Service Chief or Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A Practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the Practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of Administrative Remedies

Every Practitioner agrees that s/he will exhaust all the administrative remedies afforded in the various Sections of these Bylaws, including but not limited to the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the Medical Center or its agents.

7.5 Reporting Requirements

The CEO or his/her designee shall be responsible for assuring that the Medical Center satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a Practitioner's privileges are limited, revoked, or in any way constrained, the Medical Center must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than three (3) months and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. Under such circumstances, the CEO or CMO, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence. A Practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the Chief of Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed their current appointment or eighteen (18) months, whichever is less. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the UTH Board. While on leave of absence, the Practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. Leaves of absence are matters of courtesy, not of right. In the event that a Practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

At least forty-five (45) calendar days prior to the termination of the leave, or at any earlier time, the Practitioner may request reinstatement by sending a written notice to the Chief of Staff. The Practitioner must submit a written summary of relevant activities during the leave if the MEC or UTH Board so requests. A Practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or UTH Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the UTH Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the Practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the Practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated is not be entitled to the procedural rights provided in Part II of these Bylaws. A request for Membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Section 9. Practitioners Providing Contracted Services

9.1 Contracted Licensed Practitioners

When the Medical Center contracts for care services with licensed practitioners (LPs), all LPs providing services under the contract are permitted to do so only after being granted privileges at the Medical Center through the mechanisms established in this Part III – Credentials Procedures Manual.

9.2 Exclusivity policy

Whenever the Medical Center contracts with qualified LPs for services that are provided on an exclusive basis, then other Practitioners must, except in an emergency or life-threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the Medical Center facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Medical Center. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

9.3 Qualifications

A Practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Medical Center must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

9.4 Discipline

The terms of these Bylaws will govern disciplinary action taken by or recommended by the MEC.

9.5 Effect of Contract or Employment Expiration or Termination

The effect of expiration or other termination of a contract upon a Practitioner's staff appointment and clinical privileges is governed solely by the terms of the Practitioner's contract with the Medical Center. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the Practitioner's staff appointment status or clinical privileges.

Section 10. Medical Administrative Officers

10.1 A medical administrative officer is a Practitioner engaged by the Medical Center either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other Practitioners under the officer's direction.

10.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other Members.

10.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

10.3.1 Where a contract exists between the officer and the Medical Center, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.

10.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the UTH Board.

10.3.3 A medical administrative officer has the same procedural rights as all other Members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract, a consequence of removal from office.