Lovelace
Women's Hospital

Medical Staff Bylaws
Part I: Medical Staff
09-12-05

Revised 12/06, 4/07, 5/08, 5/09, 3/11, 11/12, 05/18

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ARTICLE I. MEDICAL STAFF PURPOSE & AUTHORITY

Section 1. Purpose

The purpose of this Medical Staff is to organize the activities of qualified physicians and other clinical practitioners who practice at Women's Hospital in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Hospital's Governing Board. The Medical Staff provides oversight of care, treatment and services provided by clinicians with privileges at Women's Hospital. The members of the Medical Staff work together as an organized body to promote a uniform standard of quality patient care, treatment and services and to offer advice, recommendations, and input to the Chief Executive Officer (CEO) and the Governing Board. The Medical Staff is an organ of the hospital which promulgates bylaws, policies and procedures to determine its governance and administrative structures and the processes for carrying out its work, subject to the ultimate authority of Governing Board.

Section 2. Authority

Subject to the authority and approval of the Governing Board, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the corporate bylaws of the Hospital.

ARTICLE II. MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

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

Section 2. Qualifications for Membership

2.1 Specific qualifications for membership are delineated in Part III of these Bylaws (the Credentials Procedure Manual).

2.2 General qualifications include evidence of the following:

a. (1) current licensure,
(2) the applicant is not currently excluded by the government from participation in federal health insurance programs such as Medicare or Medicaid. This does not mean that the applicant must participate in these insurance programs.
(3) adequate education, training, experience and evidence of current competence and sound clinical judgment to warrant all privileges requested,
(4) the ability to safely and competently meet the obligations of the Medical Staff category requested, and the physical and mental ability to safely and competently perform the clinical privileges requested, and
(5) demonstration to the satisfaction of the Medical Staff and Governing Board that patients applicant may treat can reasonably expect quality medical care; and

b. willingness to properly discharge the responsibilities established by the Hospital;

c. any applicable office or residence location requirements established by the Governing Board are satisfied;

d. the applicant is requesting privileges in a specialty which is neither subject to an exclusive contract granted by the Governing Board nor closed in accordance with any Medical Staff development plan adopted by the Governing Board;

e. compliance with professional liability insurance requirements as set out in these bylaws or in Medical Staff policies;

f. an ability and willingness to work cooperatively with other clinicians and Hospital staff in a professional manner and in compliance with established Medical Staff and Hospital policies;

g. compliance with any other criteria for eligibility that may be established by the Governing Board.

Exemptions from any of these criteria may be allowed by the Governing Board after consultation with the Medical Staff.

Section 3. Nondiscrimination

The Women's Hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, disability unrelated to the provision of patient care, or on any other basis prohibited by applicable law, to the extent the Applicant is otherwise qualified.

Section 4. Conditions and Duration of Appointment

The Governing Board shall make initial appointment and reappointment to the Medical Staff. The Governing Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC). Appointment and Reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months, with provisional status for the first six (6) months. At the end of the six-month period, a review will be completed to include quality of care and utilization and a final staff status (Active vs. Associate) will be assigned. *(revised 5/18/2006)*

Section 5. Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and clinical Privileges will be processed only when the potential Applicant meets the current minimum qualifying criteria approved by the Governing Board. Requested clinical privileges will be considered only when the request demonstrates compliance with any threshold criteria recommended by the MEC and approved by the Governing Board. In the event there is a request for a clinical privilege for which there are no approved criteria, the Governing Board, with input from the MEC and Hospital administration, will first determine if it will allow the privilege to be practiced at the Hospital and, if so, direct the MEC to promptly develop privileging criteria by considering required licensure, relevant training or experience, current competence, and ability to perform the privilege requested. Once specific criteria for the clinical privilege have been recommended by the MEC and approved by the Governing Board, the request for the clinical privilege will be evaluated as described in Part III of these Bylaws (the Credentials Procedure Manual).

Section 6. Responsibilities of Each Medical Staff Member

6.1 Each staff member must provide appropriate, timely, and continuous care of his/her patients.

6.2 Active staff members must be willing to participate in quality/ peer review activities, cooperate with utilization review activities of the hospital, precept new members of the medical staff, and participate, in the discharge of other Medical Staff functions as may be required. *(revised 5/18/2008)*

6.3 Active staff member must participate in the on call coverage of the emergency service and other coverage programs as determined by the MEC and Governing Board. All new appointees to the Medical Staff will participate in the on call coverage of the emergency service for the first 2 years, after which utilization will be taken into consideration. It is the responsibility of the staff member covering emergency service call to respond within 40 minutes of initial call with a second call placed within 20 minutes if no response has been received. *(revised 5/18/2008)*

6.4 Each staff member must submit to any type of health evaluation as requested by the hospital CEO, or

an officer of the Medical Staff, when deemed necessary to protect the well-being of patients or staff, when requested by the MEC or Credentials Committee as part of an investigation of the members ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any hospital or Medical Staff policies addressing physician health or impairment.

6.5 History and Physical Examination

6.5.1 It is the responsibility of the medical staff to ensure that a medical history and appropriate physical examination is performed on patients being admitted for inpatient care, and for operative and complex invasive procedures in an inpatient or outpatient setting.

6.5.2 *(added 3/22/2011)* An H&P examination must be performed and documented by the following:

6.5.2.1 The privilege to perform a history and physical examination is automatic and need not be delineated for physician members or the medical staff.

6.5.2.2 Oral and maxillofacial surgeons, if they possess the clinical privileges to do so in order to assess the medical, surgical/anesthetic risks of the proposed operative/other procedures.

6.5.2.3 Dentists and podiatrists are responsible for that part of the patient's H&P examination that relate, respectively, to dentistry and podiatry. They may perform a complete H&P examination if they possess clinical privileges to do so. A qualified physician must endorse the findings prior to any major high risk diagnostic or therapeutic intervention.

6.5.2.4 Allied health professionals who may perform part or all of the H&P examination include Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Physician Assistants, Nurse Practitioners and other licensed independent practitioners, when performing the H&P examination is within the scope of their practice and licensure under state law.(Revised 11/12)

6.5.2.5 Residents may complete part or all of the H&P examination. A qualified physician will countersign.

6.5.3 Each patient admitted for inpatient care shall have a complete admission history and physical examination recorded by a qualified practitioner who has been credentialed and granted privileges to perform a history and physical examination within twenty-four (24) hours of admission, and immediately prior to any surgical procedure(s) requiring anesthesia. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. At a minimum, the history and physical examination and report thereof shall consist of an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission, including the chief complaint, history of present illness, relevant medical history, medication, allergies, comprehensive physical exam, statement of conclusions or impressions, and a plan of action. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission, the record shall be considered delinquent and the Chief of Staff or his/her designee or the CEO or his designee may take appropriate steps to enforce compliance.

A history and physical performed within thirty (30) days prior to hospital admission may be

used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed, the patient was examined and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission, and immediately prior to any surgical procedure(s) requiring anesthesia.

All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.(revised 11/12)

6.6 Each staff member must abide by the Bylaws, rules and regulations, and other policies, procedures, and plans of the Hospital and the Medical Staff, including but not limited to the Medical Staff and hospital policies on professional conduct and behavior.

6.7 Each staff member 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 Governing Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession.

6.8 Other responsibilities: Each Medical Staff member must:

Immediately notify the CEO and the Credentials Committee, or their designee, of any change in the information provided on his or her application for Medical Staff membership or clinical privileges, or if he or she ceases to meet the standards of the Hospital as set forth in these Bylaws, in the rules and regulations of the Medical Staff, and in any other applicable policies and procedures, in each case as required for continued enjoyment of Medical Staff membership and/or clinical privileges;

Notify the CEO immediately of any and all malpractice claims threatened in writing or filed against the medical staff member;

Reasonably assist the Hospital in fulfilling its uncompensated or partially compensated care obligations within the areas of his or her professional competence and clinical privileges;

Use the electronic medical records systems adopted by the hospital; and

Release from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the medical staff member and his or her credentials.

Section 7. Medical Staff Member Rights

7.1 Each member of the Medical Staff in the active category has the right to an audience with the MEC on matters relevant to the responsibilities of the MEC. In the event such member is unable to resolve a matter of concern after working with an appropriate Medical Staff leader(s), that member 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.

7.2 Each member of the Medical Staff in the active category has the right to initiate a recall election of a Medical Staff Officer by following the procedure outlined in Article V, Section 7 of these Bylaws, regarding removal and resignation from office.

7.3 Each member of the Medical Staff in the active category may request a general staff meeting to discuss a matter relevant to the Medical Staff. Upon presentation of a petition signed by twenty-five percent (25%) of the members of the active category, 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.

7.4 Each member of the Medical Staff in the active category may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by twenty-five percent (25%) of the active category. When the MEC has received such petition, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or (2) schedule a meeting with the petitioners to discuss the issues.

7.5 Each member of the Medical Staff in the active category may call for a Clinical Service meeting by presenting a petition signed by 34% of the members of the Service if the Service has more than 10 members or 51% of the members if the Service has less than 10 members. Upon presentation of such a petition the Service Chief will schedule a Service meeting.

7.6 The above Sections 7.1 - 7.5 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. Section 7.7 and Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provide recourse in these matters.

7.7 Any Medical Staff member has a right to a hearing/appeal pursuant to and under the circumstances described in Medical Staff's hearing and appeal plan (Part II of these Bylaws).

Section 8. Staff Dues

8.1 Annual Medical Staff dues, if any, shall be determined by the MEC. Failure of a Medical Staff member to pay dues shall be considered a voluntary resignation from the Medical Staff. The Medical Executive Committee may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

ARTICLE III. CATEGORIES OF THE MEDICAL STAFF *(revised 5/18/2008)*

Section 1. The Active Category

1.1 **Qualifications:** Active Staff members must be involved in thirty (30) patient contacts per two year appointment period. A patient contact is defined as an inpatient admission, consultation, referral for inpatient admission or an inpatient or outpatient surgical procedure at the Women's Hospital except as expressly waived for members who document their efforts to support the Hospital's patient care mission to the satisfaction of the MEC and Governing Board.

In the event that a member of the active staff category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all Bylaws, Rules, Regulations, and policies of the staff, the member may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

1.2 **Prerogatives**: Members of the active staff category may:

1.2.1 Exercise such clinical privileges as are granted by the Governing Board

1.2.2 Vote on all matters presented by the Medical Staff and by the appropriate Service and committee(s) to which the member is assigned.

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

1.3 **Responsibilities:** Member of the active staff category shall:

1.3.1 Contribute to the organizational and administrative affairs of the Medical Staff.

1.3.2 Actively participate as requested or required in activities and functions of the Medical Staff, including quality and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities and in the discharge of other staff functions as may be required**.** *(revised 5/18/2006)*

1.3.3 Fulfill any meeting attendance requirements as established by these Bylaws or by action of the MEC or Governing Board.

1.3.4 Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

Section 2. The Associate Category

2.1 Qualifications: Appointees to this category must be involved in less than 30 patient contacts per two year appointment period. A patient contact is defined as an inpatient admission, consultation, referral for inpatient admission or an inpatient or outpatient surgical procedure at the Women's Hospital except as expressly waived for members who document their efforts to support the Hospital's patient care mission to the satisfaction of the MEC and Governing Board. *(revised 5/18/2008)*

2.2 **Prerogatives:** Members of the associate staff category may:

2.2.1 Exercise such clinical privileges as are granted by the Governing Board.

2.2.2 Attend Medical Staff meetings and Clinical Service meetings of which he or she is an appointee and any staff or hospital education programs. Members of the associate category may not vote on matters before the entire medical staff and may not be an Officer of the Medical Staff. Members of the associate category may attend Medical Staff Committees other than the Medical Executive Committee, but may not vote on matters that come before such committees. *(revised 5/2008, 11/2012)*

2.3 **Responsibilities:** Members of this category shall:

2.3.1 Contribute to the organizational and administrative affairs of the Medical Staff.

2.3.2 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, monitoring activities and in the discharge of other staff functions as may be required**.**

2.3.3 Fulfill any meeting attendance requirements as established by these Bylaws or by action of the MEC or Governing Board.

2.3.4 Fulfill or comply with any applicable Hospital or Medical Staff policies and procedures.

Section 3. The Referring Category *(added 5/12/2009)*

3.1 Qualifications: The Referring Medical Staff shall consist of members who meet the general qualifications set forth in Section 3.2(a) of these Medical Staff Bylaws and do not provide patient care in this Hospital.

3.2 **Prerogatives:** Members of the referring staff category may:

3.2.1 Refer patients to the Hospital for outpatient testing and/or procedures;

3.2.2 Refer patients to Active Staff members or Hospitalists for inpatient treatment. Referring Staff may visit their referred patients in the Hospital, review patients' medical records and receive information concerning patients' medical condition and treatment, but may not participate in any inpatient treatment or make any entries in the medical record;

3.2.3 Attend meetings of the Medical Staff and the department of which he/she is a member, including open committee meetings, in a non-voting capacity; and

3.2.4 Attend Continuing Medical Education programs at the Hospital.

3.3 **Limitations:** Members of the Referring Medical Staff shall not be eligible to:

3.3.1 Vote, serve on committees, or hold offices in the Medical Staff;

3.3.2 Admit and/or treat patients;

3.3.3 Order tests on inpatients; or

3.3.4 Exercise any clinical privileges.

3.4 **Responsibilities:** Members of the Referring Medical Staff will be expected to:

3.4.1 Adhere to the ethics of their respective professions;

3.4.2 Be able to work cooperatively with others;

3.4.3 Complete appointment and reappointment requirements;

3.4.4 Provide the following information when referring a patient for a diagnostic test or study:

(a) physician name, State license number, office address and telephone number; and

(b) a written order from the physician's office; and

3.4.5 Review all results of tests ordered and provide for such further outpatient medical care as the patient's condition may indicate. Since such patient care shall occur outside of the Hospital, neither the Medical Staff nor the Hospital shall be responsible for reviewing such care through the Performance/Quality Improvement Process or otherwise.

ARTICLE IV. ALLIED HEALTH PROFESSIONALS (AHP) *(added 11/2012)*

Section 1. Categories

1.1 Allied Health Professionals ("AHPs") shall be identified as any person(s) other than practitioners who are granted privileges to practice in the Hospital and are directly involved in patient care. Such persons may be employed by physicians on the staff; but whether or not so employed, must be under the care of a practitioner who is directly under the supervision of a member of the medical staff.

Section 2. Qualifications

2.1 Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

2.2 AHPs must:

2.2.1 Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

2.2.2 Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective profession, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

2.2.3 Have professional liability insurance in the amount required by these bylaws;

2.2.4 Provide a needed service within the Hospital; and

2.2.5 Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

Section 3. Prerogatives

3.1 Upon establishing experience, training and current competence, AHPs, as identified in Section 1, shall have the following prerogatives:

3.1.1 To exercise judgment within the AHP's area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care;

3.1.2 To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff; and

3.1.3 To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.

Section 4. Conditions Of Appointment

4.1 AHPs shall be credentialed in the same manner as outlined in Part III of the Medical Staff Bylaws for credentialing of practitioners. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

4.2 Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the Credentials Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the AHP an opportunity to be heard by the Committee concerning the AHP's grievance. Before the appearance**,** the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. A record of the appearance shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the AHP.

4.3 The AHP shall have a right to appeal to the Board any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Credentials Committee decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5)

days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

4.4 AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan.

4.5 If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

Section 5. Responsibilities

5.1 Each AHP shall:

5.1.1 Provide his/her patients with continuous care at the generally recognized professional level of quality;

5.1.2 Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

5.1.3 Discharge any committee functions for which he/she is responsible;

5.1.4 Cooperate with members of the Medical Staff, administration, the Governing Board and employees of the Hospital;

5.1.5 Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.1.6 Participate in performance improvement activities and in continuing professional education;

5.1.7 Abide by the ethical principles of his/her profession and specialty; and

5.1.8 Notify the CEO and the Chief of Staff, or their designee, immediately if:

5.1.8.1 His/Her professional license in any state is suspended or revoked;

5.1.8.2 His/Her professional liability insurance is modified or terminated;

5.1.8.3 He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or

5.1.8.4 He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or clinical privileges.

5.1.9 Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

ARTICLE V. OFFICERS of the MEDICAL STAFF

Section 1. Officers of the Medical Staff

1.1 Chief of Staff

1.2 Chief of Staff Elect (Chief Elect)

1.3 Secretary

1.4 Immediate Past Chief of Staff

Section 2. Qualifications of Officers

Officers must be members in good standing of the active category, have previously served in a leadership position on a Medical Staff, (e.g. Department or Service Chair or Chief, Committee Chair or Committee member), indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges, have a history of attendance at continuing education relating to Medical Staff leadership or be willing to do so during their term of office, have demonstrated an ability to work well with others and compliance with the professional conduct policies of the Hospital, and should have excellent administrative and communication skills. The Medical Staff Nominations Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

Officers may not simultaneously hold leadership positions on another hospital Medical Staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in automatic removal from office unless the Governing Board determines that continuation in office will serve the interests of the Hospital. The Governing Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

Section 3. Election of Officers

3.1 Every other year or as needed, the MEC shall appoint a Nominations Committee chaired by the Immediate Past Chief of Staff and comprised of at least three active staff members appointed the MEC. Wherever possible, at least one of these appointees should be a past Chief of Staff. If the Immediate Past Chief of Staff is not available then the MEC may appoint a chair at its discretion. The Nominations Committee shall offer at least one nominee for each office in which a vacancy is expected. Nominations must be announced, and the names of the nominees distributed to all members of the active Medical Staff at least thirty (30) days prior to the election. The Chief of Staff position is not elected in the manner described above. When the term for the Chief of Staff has expired; the Chief of Staff Elect will assume the duties of Chief of Staff for a two year term.(revised 11/12)

3.2 A petition signed by at least twenty-five percent (25%) of the appointees of the active staff may also make nominations. Such petition must be submitted to the Chief of Staff at least fourteen (14) days prior to the election for placement on the ballot. The candidate nominated by petition must be confirmed by the Nominations Committee to meet the qualifications in Article V, Section 2 above before he/she can be placed on the ballot.

3.3 Officers shall be elected every other year at the annual meeting of the Medical Staff by a majority vote of those casting ballots at the meeting. Only members of the active category shall be eligible to vote. *(revised 5/18/2008)*

Section 4. Term of Office

All officers serve a term of two (2) years, unless they earlier resign or are removed hereunder. Officers shall take office in the month following the election. *(revised 5/18/2008)*

Section 5. Vacancies of Office

When the Office of Secretary becomes vacant during the Medical Staff year the MEC shall appoint an interim Secretary to fill the remainder of the vacated term. If the Office of Chief of Staff becomes vacant the Chief-Elect will fill the remainder of the vacated term and the Secretary will become Chief-Elect. Where the Chief-Elect position becomes vacant during the Medical Staff year, the Secretary will fill the remainder of the vacated term. Any vacancy in the position of Immediate Past Chief of Staff will not be filled.

Section 6. Duties of Officers

6.1 Chief of Staff – The Chief of Staff shall serve as the chair of the MEC and will fulfill duties specified in Part IV of these Bylaws (Organization and Functions Manual).

6.2 Chief of Staff-Elect – In the absence of the Chief of Staff, the Chief-Elect shall assume all the duties and have the authority of the Chief of Staff. He or she shall perform such further duties to assist the Chief of Staff as the Chief of Staff may from time to time request.

6.3 Secretary – This Officer will collaborate with the hospital's Medical Staff office, assure maintenance of minutes, attend to correspondence, act as Medical Staff treasurer, and coordinate communication within the Medical Staff. He or she shall perform such further duties to assist the Chief of Staff as the Chief of Staff may from time to time request.

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. He or she shall perform such further duties to assist the Chief of Staff as the Chief of Staff may from time to time request.

Section 7. Removal and Resignation from Office

7.1 The Medical Staff may remove from office any Officer by petition of twenty-five percent (25%) of the active staff members and a subsequent affirmative vote for removal by two-thirds (2/3) of the votes cast by members of the active staff via ballot.

Automatic removal shall be for failure to conduct those responsibilities assigned within these Bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements damaging to the Hospital, its goals, or programs, or an automatic or summary suspension of clinical privileges which lasts for more than thirty days. The existence of such failures will be determined by the Hospital's Governing Board after consulting with the Joint Conference Committee.

7.2 Resignation: Any elected officer of the Medical Staff 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 8. Conflict of Interest of Medical Staff Members (added 11/12)

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff member shall use his/her position to obtain or accrue any improper benefit. All Medical Staff members shall at all times avoid even the appearance of improperly influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

8.1 Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to membership on the governing body, executive committee, or service chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

8.2 Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

8.3 Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

8.4 Business practices that may adversely affect the hospital or community.

In addition to the foregoing a new Medical Staff leader (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any service, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Governing Board) shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The Secretary will provide each MEC member with a copy of each leader's written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. Failure to disclose a conflict as required by this Section 8 or failure to abstain from voting on an issue in which the Medical Staff member has an interest other than as a fiduciary of the Medical Staff may be grounds for corrective action. In the case of Medical Staff leaders, a breach of these provisions is deemed sufficient grounds for removal of a breaching leader from his/her leadership position by the remaining members of the MEC or the Board on majority vote.

ARTICLE VI. MEDICAL STAFF ORGANIZATION

Section 1. Organization of the Medical Staff

1.1 The Medical Staff of Women's Hospital shall be organized as a non-departmentalized staff. The MEC may, upon approval of the Hospital's Governing Board, recognize any group of Practitioners who wish to organize themselves into a Clinical Service. Any Clinical Service, if organized, shall not

be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the Clinical Service is making a formal recommendation to the MEC. A Clinical Service recognized by the MEC shall identify a Service Chief. Clinical Services are completely optional, shall be advisory in nature only with no binding authority, and shall exist to perform any of the following activities:

1.1.1 Continuing education/discussion of patient care;

1.1.2 Grand rounds;

1.1.3 Discussion of policies and procedures;

1.1.4 Discussion of equipment needs;

1.1.5 Development of recommendations to the MEC or Management;

1.1.6 Participation in the development of criteria for Clinical Privileges when requested by the Credentials Committee or MEC; and

1.1.7 Discussion of a specific issue at the request of a Medical Staff committee or the MEC.

1.2 The current Clinical Services that are organized by the Medical Staff and formally recognized by the MEC shall be listed Part IV of the Bylaws (the Organization and Functions Manual).

Section 2. Functions of Clinical Service Chiefs

2.1 Clinical Service Chiefs shall carry out the responsibilities assigned in Part IV of these Bylaws the (Organization and Functions Manual).

2.2 Service chiefs shall be appointed jointly by the incoming chief of staff and the chief executive officer in the quarter prior to the inception of his/her term as chief of staff. The term of the chief of the service will be for a period of two years.

Section 3. Assignment to Clinical Service

The MEC may, 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. Clinical privileges are independent of service assignment.

ARTICLE VII. COMMITTEES

Section 1. Designation and Substitution

There shall be an MEC and such other standing and special committees as established by the MEC and enumerated in Part IV of the Bylaws (the Organization and Functions Manual.) Those functions requiring participation of, rather than direct oversight by, the staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The MEC and appropriate Medical Staff leaders may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

Section 2. Medical Executive Committee

2.1 Committee Membership:

2.1.1 The MEC shall be a standing committee consisting of the Medical Staff Officers, Immediate Past Chief of Staff, and five (5) additional members of the active staff. One of these members shall be elected at large from the active medical staff membership. The remaining members

will be appointed by the Chief of Staff from among those active members holding positions as Clinical Service Chiefs and Vice Chiefs, Committee Chairs, or Physician Advisors/Liaisons, members shall hold at-large positions elected by the medical staff membership. The CEO may attend all MEC meetings. *(revised 5/18/2008)*

2.1.2 An Officer who resigns or is removed from his position in accordance with Article V, Section 7 above, or a Clinical Service Chief, Committee Chair or Physician Advisor/Liaison who resigns or is removed from his position, will automatically lose his membership on the MEC. At-large members of the MEC may be removed in accordance with the mechanism outlined in Article V, Section 7 for Officers.

2.2 The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the medical Staff, Hospital Administration and the Board and shall be empowered to act for the medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. When approval of procedural details related to credentialing, corrective action, or selection and duties of department leadership are delegated to the MEC, it shall represent to the Board the organized medical staff's views on issues of patient safety and quality of care. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 2 and additional functions may be delegated or removed through amendment of this Section 2. *(added 3/22/2011)*

2.3 DUTIES: The duties of the MEC shall be to:

2.3.1 Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws, except for those decisions requiring action by the full Medical Staff, and provide oversight for all Medical Staff functions.

2.3.2 Coordinate the implementation of policies adopted by the Governing Board;

2.3.3 Submit recommendations to the Governing Board concerning all matters relating to appointment, reappointment, staff category, Clinical Service assignments, Clinical Privileges, and corrective action;

2.3.4 Account to the Governing Board and to the staff for the overall quality and efficiency of professional patient care services provided in the Hospital by individuals with Clinical Privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

2.3.5 Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff appointees including collegial and educational efforts and investigations, when warranted;

2.3.6 Make recommendations to the Governing Board on medico-administrative and Hospital management matters;

2.3.7 Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;

2.3.8 Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

2.3.9 Represent and act on behalf of the full staff subject to such limitations as may be imposed by these Bylaws;

2.3.10 Formulate and recommend to the Governing Board Medical Staff rules, policies, and procedures;

2.3.11 Request evaluations of Practitioners privileged through the Medical Staff process in instances in which there is question about an Applicant or member's ability to perform privileges requested or currently granted;

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

2.3.13 Consult with administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the Hospital by entities outside the Hospital; and

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

2.3.15 Hold Medical Staff leaders and medical staff committees accountable for fulfillment of their duties and responsibilities.

2.3.16 Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws.

2.4 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.

ARTICLE VIII. MEDICAL STAFF MEETINGS

Section 1. Meetings of the entire Medical Staff

1.1 An annual meeting of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously at least 14 days in advance of the meeting.

1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the Medical Staff at which a quorum is present is the action of the group. Action may be taken without a meeting by the staff by presentation of the question to each member eligible to vote, in person, via telephone, fax, 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.

1.3 General Medical Staff Meetings. Such meetings may be called by such persons, and for such purposes, as provided in Article I, Section 7.3 of these Bylaws.

1.4 Special Meetings of the Medical Staff

1.4.1 The Chief of Staff or the Governing Board may call a special meeting of the Medical Staff at any time. 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.

1.4.2 Written or printed notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent via U.S. mail, postage prepaid, to each member of the Medical Staff at least seven (7) 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.

Section 2. Regular Meetings of Medical Staff Committees

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

Section 3. Special Meetings of Committees

A special meeting of any committee may be called by or at the request of the chairperson thereof or by the Chief of Staff.

Section 4. Quorum

4.1 Medical Staff meetings: those present or those eligible medical staff members voting on an issue.

4.2 Clinical Service meetings or Medical Staff committees: Those present or those eligible medical staff members voting on an issue.

4.3 Medical Executive Committee, Credentials Committee and Medical Staff Peer Review Committees: A quorum will exist when 50% of the members are present. (added 11/12)

Section 5. Attendance Requirements

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

5.1.1 Special meeting attendance requirements: Whenever suspected deviation from standard clinical or professional practice is identified, the Chief of Staff or other appropriate medical staff leader 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 (with confirmation of receipt) of the conference at least five (5) days prior to the conference, including the date, time, place, a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such conference after two notices, unless excused by the MEC upon showing good cause, will be considered a voluntary resignation of Medical Staff membership. Such termination will not give rise to a fair hearing, but will automatically be rescinded upon the Practitioner's participation in the previously referenced conference.

5.1.2 Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of Clinical Privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

Section 6. Participation by Chief Executive Officer

The CEO or any representative assigned by the CEO may attend any committee or Clinical Service meetings of the Medical Staff.

Section 7. Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the individual who is 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 edition of *Robert's Rules of Order* shall determine procedure.

Section 8. Notice of Meetings

Written 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 a committee not less than two (2) 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.

Section 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 a Clinical Service. Such action will constitute a recommendation only, which will not have any binding force or effect, and will then be forwarded to the MEC for information or for further action by the MEC.

Section 10. Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. A permanent file of the minutes of each meeting shall be maintained. *(revised 5/18/2008)*

Article IX: Conflict Resolution

Conflict resolution: In the event the Governing Board acts in a manner contrary to a recommendation by the MEC the matter may (at the request of the MEC) be submitted for a Joint Conference composed of the officers of the Medical Staff and an equal number of members of the Governing Board for review and recommendation to the full Governing Board. The committee will submit its recommendation to the Governing Board within thirty (30) days of its meeting. The ultimate decision is for the Governing Board to make in its sole discretion.

The Chairperson of the Governing Board or the Chief of Staff may call for a Joint Conference as described above at any time and for any reason in order to seek direct input from the Medical Staff leaders, clarify any issue, or relay information directly to Medical Staff leaders.

When conflict arises between the medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. An ad hoc committee selected by the Board Chair shall meet, as needed, with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the medical staff or the MEC or to limit the Board's final authority as to such issues. *(revised 3/22/2011)*

Article X. General Provisions

Section 1. Rules of Construction

The time periods specified within these Bylaws are intended to be guidelines for action. Any action of the Medical Staff, Governing Board, or Hospital shall not be invalidated solely because such party did not strictly comply with specified time periods.

These Bylaws are intended to be read as a whole, and the fact that certain sections of these Bylaws may mention only particular rights or duties of Medical Staff members should not be construed to abrogate, limit, or exclude any rights or duties of such members mentioned in any other sections of these Bylaws

If any provision in these Bylaws requires judicial interpretation, the Medical Staff and Hospital, and each practitioner by accepting Medical Staff membership or clinical privileges, hereby agree and acknowledge that the judicial body interpreting or construing such provision shall not apply the assumption that the terms hereof shall be more strictly construed against the one who either itself or through its agents prepares the same. The Hospital, the Governing Board, the Medical Staff, the Medical Staff members, and all other practitioners exercising clinical privileges hereby agree that they and their agents have participated equally in the preparation of these Bylaws.

If any provision of these Bylaws, or the application of such provision to any person or circumstance, shall be held invalid by any court, government agency or regulatory body, the remainder of these Bylaws, or the

application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby and shall remain in full force and effect. To the extent permitted by applicable law, the parties hereto hereby waive any provision of law that renders any provision hereof prohibitive or unenforceable in any respect.

No waiver of any provision of these Bylaws shall be valid except in specific instances when agreed to by each party affected by the waiver. The failure of the Medical Staff, its individual members, the Governing Board or Hospital to insist upon strict adherence of any provision of these Bylaws shall not be considered a waiver and shall not justify any subsequent waiver.

These Bylaws have been drafted to comply with the provisions of both HCQIA and, to the extent not in conflict with HCQIA, applicable State peer review law. To the maximum extent practicable, the provisions of these Bylaws shall be interpreted as consistent with the requirements of the foregoing laws.

Section 2. Relationship between Hospital and Medical Staff Members.

Notwithstanding anything to the contrary herein, it is understood and agreed that nothing contained in these Bylaws shall create in fact, by implication or otherwise, a contract of any nature between the Medical Staff or any member of the Medical Staff and the Hospital or the Governing Board.

Section 3. Priority of Authorities

To the extent that there is any conflict between any of the various documents granting authority to the Corporation, the Governing Board and the Medical Staff, the priority of the documents shall be as follows: (1) the Corporation's Bylaws shall have priority over the Governing Board Bylaws, these Bylaws, and the rules and regulations of the Medical Staff, (2) the Governing Board Bylaws shall have priority over the Medical Staff Bylaws and the rules and regulations of the Medical Staff, and (3) the Medical Staff Bylaws shall have priority over the rules and regulations of the Medical Staff. Nonetheless, to the extent practicable, these documents shall be construed so as to avoid conflict.

Section 4. Reserved Authority

Notwithstanding anything to the contrary in these Bylaws, the Governing Board hereby specifically reserves authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff or granted clinical privileges in the Hospital. Except for such actions that would if, taken in accordance with the procedures otherwise designated in these Bylaws, constitute an adverse action entitling the affected practitioner to a hearing under the Fair Hearing Plan incorporated within these Bylaws, actions taken by the Governing Board may, but need not, follow the procedures in such Fair Hearing Plan. Further, and without limiting the foregoing, the Governing Board hereby specifically reserves all authority with respect to making financial decisions for the Hospital, including, without limitation, initiating service lines, discontinuing service lines, and entering into exclusive service arrangements.

Article XI. Review, Revision, Adoption, and Amendment

Section 1. Medical Staff Responsibility

When the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they must first communicate the proposal to the MEC. Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulations, the MEC may provisionally adopt, and the Board provisionally approves, an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of

and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Part I; Article IX shall be implemented. *(revised 3/22/2011)*

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 Services of these Bylaws. Where the Medical Staff fails to maintain or create bylaws, procedures, plans, policies, or rules & regulations which comply with legal or accreditation requirements, the Governing Board may on its own initiative amend such documents to the degree necessary to achieve compliance. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these bylaws), and shall advise the staff of the basis for its action in this regard.

Section 2. Methods of Adoption and Amendment of the Medical Staff Bylaws

All proposed amendments to these Medical Staff Bylaws whether originated by the MEC, another standing committee, a member of the active category of the staff, or the Governing Board must be reviewed and discussed by the MEC prior to a MEC vote.

The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose. Following a vote by the MEC, each member of the active category of the Medical Staff will be eligible to vote on the proposed amendment to these Bylaws via printed ballot or in a manner determined by the MEC. All active members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. To be adopted, such changes must receive a majority of the votes cast by the eligible members of the Medical Staff. Amendments so adopted shall be effective when approved by the Governing Board.

The MEC may adopt such amendments to these Bylaws and to the Investigation, Corrective Action, Hearing and Appeal Plan as are, in the committee's good faith and reasonable judgment, technical or legal modifications or clarifications; reorganization or renumbering or those needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Governing Board but must be approved by the CEO.

Section 3. Staff Rules & Regulations & Policies (added 11/12)

3.1 Subject to approval by the Board, the Medical Staff hereby delegates authority to the MEC to adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular MEC meeting at which a quorum is present and without previous notice, or at any special MEC meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions

3.2 Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

3.3 Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to

comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 3.1(c) of this Article shall be implemented.

3.4 Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the MEC or to limit the Board's final authority as to such issues.

3.5 Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and (except in the case of a provisional adoption provided for in Section 3.1(b) of this Article) no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

3.6 Interpretation

Interpretation of these rules and regulations will be the responsibility of the Medical Executive Committee.

Adopted by:

Chief of Staff	Date:
Chief of Executive Officer	Date:
Chairman, Governing Board	Date: