

**NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO**

MEDICAL STAFF

BYLAWS

Revised: October 31, 2025

**MEDICAL STAFF OFFICE
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ADOPTION & AMENDMENT

These Medical Staff Bylaws shall be adopted and amended in accordance with the procedure set forth in Article XIII, shall replace any previous Bylaws, and shall become effective when approved by the Board of Directors.

ADOPTED BY THE MEDICAL STAFF OF NATIONWIDE CHILDREN'S HOSPITAL: November 29, 2021

APPROVED BY THE BOARD OF DIRECTORS OF NATIONWIDE CHILDREN'S HOSPITAL: November 16, 2021

PREAMBLE

Whereas, Nationwide Children's Hospital is a non-profit corporation organized under the laws of the State of Ohio; and,

Whereas, the Hospital's purpose is to serve primarily as a hospital providing patient care, education, and research to children and adults with childhood illnesses; and,

Whereas, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Board of Directors, and that the cooperative efforts of the Medical Staff, the Chief Medical Officer, the Chief Executive Officer, and Board of Directors are necessary to fulfill the Hospital's obligations to its patients;

Therefore, the Practitioners in this Hospital shall organize themselves into a Medical Staff in conformity with the Medical Staff Bylaws and Policies.

DELEGATION OF AUTHORITY

Since final accountability for the quality of care rendered at the Hospital rests with the Board of Directors, they, as the governing body, grant to qualified and eligible Practitioners and Advanced Practice Providers Medical Staff appointment and/or Privileges, as applicable, upon the recommendation of the Medical Staff through its duly authorized officers, committees, and Members.

The Medical Staff is responsible to the Board of Directors to see that Practitioners and Advanced Practice Providers granted, as applicable, Medical Staff appointment and/or Privileges at the Hospital provide care, treatment, and/or services within the scope of the Privileges granted to them.

The Board of Directors has delegated authority to the Medical Staff to be self-governing in accordance with the requirements set forth in the Medical Staff Bylaws and Policies and to form its committees freely so that the Medical Staff as a professional body might review its Members' competence and make recommendations to the Board of Directors for official action. The intent of this delegation of authority is to promote the continual advancement of health care.

Subject to the authority and approval of the Board, the Medical Staff shall exercise such power as is reasonably necessary to discharge its responsibilities under the Medical Staff Bylaws and Policies, and under the Hospital's governing documents.

DEFINITIONS

Advanced Practice Provider or APP means those physician assistants, advanced practice registered nurses, optometrists, and other eligible allied health professionals who have applied for and/or been granted Privileges to practice at the Hospital either independently or in collaboration with or under the supervision of a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

Adverse means a recommendation or action of the Medical Executive Committee or Board that (1) denies or terminates Medical Staff appointment; or (2) denies, limits (*i.e.*, suspension, restriction, *etc.*), or terminates the Privileges of a Medical Staff Member on the basis of professional conduct or clinical competence, or as otherwise defined in these Medical Staff Bylaws or the Fair Hearing Policy, for a period in excess of fourteen (14) days.

Affiliate Hospital(s) means Nationwide Children's Hospital Toledo.

Board of Directors or **Board** means the governing body of the Hospital. A reference to the "Board of Directors" or "Board" shall include the Board's designee(s).

Chief Executive Officer or **CEO** means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital.

Chief Medical Officer or **CMO** means the individual appointed by the Hospital to be responsible for the clinical work, medical education, and quality of patient care delivered throughout the Hospital and its related companies.

Clinical Privileges or **Privileges** means the permission granted by the Board of Directors to a Practitioner or Advanced Practice Provider to render designated patient care, treatment, and/or services at/for the Hospital within defined limits based upon the Practitioner's or APP's professional license, education, training, experience, competence, ability, character, and judgment.

Dentist means an individual who has received a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree; who is currently licensed to practice dentistry

in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies; and whose practice is in the area of oral and maxillofacial surgery, general dentistry, or a specialty thereof.

Ex Officio means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided in the Bylaws or Policies, means with voting rights. Persons serving in an *Ex-Officio* capacity shall be counted in determining the existence of a quorum unless otherwise provided in the Bylaws or Policies.

Federal Healthcare Program means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

Good Standing means the Practitioner, during the time at issue, meets all applicable requirements for his or her appointment category and Department and is not currently experiencing a suspension or curtailment of Privileges at the Hospital other than an automatic suspension for delinquent medical records.

Hospital means Nationwide Children's Hospital including all its clinical departments, programs, services, and provider-based locations.

Medical-Administrative Officer means a Practitioner employed by or otherwise under contract with the Hospital on a full or part-time basis whose duties include certain responsibilities that are administrative in nature.

Medical Executive Committee or MEC means the Executive Committee of the Medical Staff.

Medical Staff means those Medical Staff Members with such rights and responsibilities as defined in the Medical Staff category to which each has been appointed.

Medical Staff Bylaws or Bylaws means the articles herein and amendments thereto that constitute the basic governing document of the Medical Staff.

Medical Staff Department or Department means those clinical services designated as Medical Staff Departments as provided for in the Medical Staff Organizational Policy. Departments may be further divided into Sections led by Section Chiefs.

Medical Staff Department Chief or Department Chief means a Member of the active Medical Staff with Privileges appointed to serve as the administrative head of a Medical Staff Department and who reports to the CMO and, if applicable, the Surgeon-in-Chief.

Medical Staff Member or Member means a Practitioner who has been granted an appointment to the Medical Staff of the Hospital with or without Privileges. A Medical Staff Member must have applied for and been granted Privileges unless his/her appointment is to a Medical Staff category without Privileges or unless otherwise provided in the

Medical Staff Bylaws or Policies. For purposes of the Bylaws or Policies, the term “membership” and “appointment/appointed” may be used interchangeably and shall have the same meaning.

Medical Staff Policy or Policy means those policies recommended by the Medical Executive Committee and approved by the Board that are generated to supplement the Medical Staff Bylaws. The Medical Staff Policies shall include, without limitation, the Credentials Policy, Organizational Policy, Fair Hearing Policy, Practitioner/Advanced Practice Provider Effectiveness Policy, and Advanced Practice Provider Policy.

Medical Staff President means a Member of the active Medical Staff elected to serve as the administrative leader of the Medical Staff.

Medical Staff Section Chief or Section Chief means a Member of the active Medical Staff with Privileges appointed to serve as administrative head of a Medical Staff Section subject to the authority of the Department Chief and CMO and, if applicable, the Surgeon-in-Chief.

Medical Staff Year means the period from January 1 to December 31 of each year.

Patient Encounter means a professional contact between a Practitioner and a patient whether an admission, consultation, or diagnostic, operative, or invasive procedure at the Hospital.

Physician means an individual who has received a Doctor of Medicine (“M.D.”) or Doctor of Osteopathic Medicine (“D.O.”) degree and who is currently licensed to practice medicine in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

Professional Liability Insurance means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as recommended by the MEC and approved by the Board.

Podiatrist means an individual who has received a Doctor of Podiatric Medicine (D.P.M.) degree and who is currently licensed to practice podiatry in the State of Ohio unless otherwise provided by the Medical Staff Bylaws or Policies.

Practitioner means an appropriately licensed Physician, Dentist, Podiatrist, or Psychologist.

Psychologist means an individual with a doctoral degree in psychology or school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology, who is currently licensed to practice psychology in Ohio unless otherwise provided by the Medical Staff Bylaws or Policies.

Special Notice means written notice sent by (a) certified mail, return receipt requested; or (b) personal delivery service with signed acknowledgement of receipt.

RELATED INFORMATION

Not a Contract. The Medical Staff Bylaws and Policies are not intended to and shall not create any contractual rights between the Hospital and any Practitioner or APP. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and its Practitioners and APPs.

Time Computation. Unless otherwise provided, in computing any period of time set forth in the Medical Staff governing documents, the date of the act from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the period of time is less than seven (7) days, intermediate Saturdays, Sundays, and legal holidays shall be excluded. Unless otherwise specified herein (e.g., a reference to “business days”), “days” shall mean “calendar days.”

Use of a Designee. Whenever an individual is authorized to perform a duty by virtue of his/her position (e.g., the CEO, CMO, Medical Staff President, Department Chief, etc.), then reference to the individual shall also include the individual’s designee.

**ARTICLE I
NAME AND PURPOSE**

1.1 Name

1.1-1 The name of this organization shall be the Nationwide Children's Hospital Medical Staff.

1.2 Purpose

1.2-1 The purposes of this organization are to:

- A. Provide for appropriate oversight of the care provided to patients admitted to or treated in any of the facilities, departments, or services of the Hospital.
- B. Promote a high level of professional performance for all persons authorized to practice in the Hospital, or in any of the facilities, departments, or services of the Hospital, through the appropriate delineation of Clinical Privileges that each Practitioner or APP may exercise in the Hospital, or in any of the facilities, departments, or services of the Hospital, and through an ongoing review and evaluation of each Practitioner's or APP's performance.
- C. Provide an appropriate environment that will encourage medical/other professional education, clinical research, and lead to continuous advancement in professional knowledge and skill.
- D. Initiate, maintain, and enforce the Medical Staff Bylaws and Policies for self-governance of the Medical Staff.
- E. Provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board of Directors, the Chief Medical Officer, and the Chief Executive Officer.

**ARTICLE II
QUALIFICATIONS FOR & RESPONSIBILITIES
OF MEDICAL STAFF APPOINTMENT AND PRIVILEGES**

2.1 Nature of Appointment and Privileges

2.1-1 Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Policies.

2.1-2 Medical Staff appointment/reappointment shall confer on the Practitioner only such Privileges as are granted by the Board or as otherwise provided in these Bylaws or the Credentials Policy.

2.2 Qualifications for Appointment and/or Privileges

2.2-1 Unless otherwise provided in the Medical Staff Bylaws or Policies, in order for a Practitioner to be eligible for Medical Staff appointment and/or Privileges at the Hospital a Practitioner must meet the following qualifications:

- A. Have and maintain a current, valid license/certificate issued by the State of Ohio to independently practice his/her respective profession and meet the continuing education requirements established by the applicable State licensure board.
- B. Have and maintain a current, valid Drug Enforcement Administration registration number as necessary for the Privileges requested.
- C. Provide documentation of completion of professional education as required by the applicable State licensing entity and such additional education as may be set forth in the applicable Delineation of Clinical Privileges.
- D. Provide, if applicable, documentation of successful completion of an ACGME and/or AOA approved residency in the specialty/specialties in which the applicant seeks Privileges. Applicants shall also provide documentation of successful completion of other postgraduate training programs, internships, and/or fellowships, as applicable, with specification as to pediatric training.
- E. Provide documentation of board certification and maintenance of certification in his/her area(s) of practice at the Hospital by the appropriate specialty/subspecialty board(s) in accordance with the requirements set forth in the Credentials Policy.

- F. Have and maintain current, valid Professional Liability Insurance in an amount no less than one million dollars (\$1,000,000,000) per incident and three million dollars (\$3,000,000,000) annual aggregate.
- G. Be able to participate in Federal Healthcare Programs.
- H. Have and maintain a provider number for Medicare issued by the United States Department of Health & Human Services and a provider number for Medicaid issued by the Ohio Department of Medicaid.
- I. Have not been convicted of or pled guilty to any of the violations described in division (A)(4) of section 109.572 of the Ohio Revised Code which disqualify the applicant from employment or appointment at a children's hospital pursuant to section 2151.86 of the Ohio Revised Code. In the event an applicant seeks to request a waiver of this qualification on the grounds that the applicant meets the rehabilitation standards as provided for in R.C. 109.572(A)(4), the applicant shall follow the waiver procedure set forth in Section 2.2-2 below.
- J. Satisfy such other qualifications as set forth in the applicable Medical Staff category and Privilege set.
- K. Agree to fulfill, and fulfill, the responsibilities, as applicable, set forth in the Medical Staff governing documents.
- L. Provide such other information as set forth in the Credentials Policy and as required by the Medical Staff application.

2.2-2 Waiver of Qualifications for Medical Staff Appointment and/or Privileges

- A. A written request for a waiver of a qualification for Medical Staff appointment and/or Privileges may be submitted by the Practitioner for consideration by the MEC and Board. Qualifications for Medical Staff appointment and/or Privileges may be waived, at the sole discretion of the Board, based upon exceptional circumstances and a Board determination that such waiver will serve the best interests of patient care. The MEC will make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Upon receipt of the MEC's recommendation, the Board shall either grant or deny the waiver request. Once a waiver is granted, it shall remain in effect from the time it is granted until the Practitioner's resignation or termination of Medical Staff appointment/Privileges unless a shorter time period is recommended by the MEC and approved by the Board. The Practitioner must thereafter reapply for the waiver.

- B. No Practitioner is entitled to a waiver. A determination by the Board not to grant a Practitioner's request for a waiver; or, the Hospital's inability to process an application; or, termination of a Practitioner's appointment and Privileges based upon failure to satisfy the qualifications for Medical Staff appointment and/or Privileges does not give rise to any procedural rights nor does it create a reportable event for purposes of federal or state law.

2.3 No Entitlement to Medical Staff Appointment and/or Privileges

2.3-1 No Practitioner shall be entitled to membership on the Medical Staff or to exercise particular Clinical Privileges in the Hospital merely by virtue of the fact that he/she: holds a certain degree; is duly licensed to practice his/her profession in this or in any other state; is a member of a professional organization or certified by a clinical board; had in the past, or presently has, medical staff appointment and/or privileges at this Hospital or another hospital; or is contracted with or employed by this Hospital.

2.4 Nondiscrimination

2.4-1 No applicant shall be denied appointment and/or Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability; genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

2.5 Basic Responsibilities of Practitioners Granted Medical Staff Appointment and/or Privileges

2.5-1 Unless otherwise provided in the Medical Staff Bylaws or Policies, the ongoing responsibilities of Practitioners with Medical Staff appointment and/or Privileges shall include:

- A. Providing patients with quality of care meeting the professional standards of the Hospital's Medical Staff.
- B. Abiding by the Medical Staff Bylaws and Policies, Hospital policies (including, but not limited to, the Hospital's corporate compliance program, conflict of interest policies, if applicable, and Notice of Privacy Practices distributed to patients as required by federal patient privacy regulations), and applicable accreditation standards, laws, rules, and regulations.
- C. Discharging such Medical Staff, committee, Department, Section, and Hospital functions for which he/she is responsible by Medical

Staff category, assignment, appointment, election, or otherwise, and attending Medical Staff meetings as required.

- D. Preparing and completing in a timely fashion the medical and other required records for all patients he/she admits or in any way provides care, treatment, or services for in the Hospital.
- E. Providing continuous care and supervision of his/her patients or otherwise arranging a suitable alternate to provide such care and supervision.
- F. Calling for consultation and/or assistance, as needed, in the care of patients; and, providing consultation and assistance in his/her respective area of expertise and for which he/she has Clinical Privileges when requested.
- G. Satisfying any continuing medical/other professional education requirements necessary to maintain his/her licensure or that may otherwise be established by the Medical Staff.
- H. Participating in such emergency service coverage and consultation panels as may be required by the Medical Staff to the extent applicable to the Medical Staff category to which the Practitioner is appointed.
- I. Complying with such notification requirements as set forth in these Medical Staff Bylaws and Policies.
- J. Working in a cooperative, professional manner and refraining from any conduct or activity that is disruptive to Hospital operations.
- K. Participating in, and cooperating with, peer review, quality assurance, and utilization review activities, whether related to the Practitioner or others, as requested by the Medical Staff.
- L. Cooperating in any relevant or required review of the Practitioner's or others' credentials, qualifications, clinical performance, or as otherwise required by the Medical Staff Bylaws or Policies and refraining from directly or indirectly interfering, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to perform or participate in assigned responsibilities, or otherwise.
- M. Conducting himself/herself consistent with Hospital and Medical Staff policies regarding conflicts of interest and otherwise acting in such a manner that potential conflicts of interest are specifically stated prior to discussions and/or voting on issues where such a conflict may exist.

- N. Adhering to applicable professional ethical practice guidelines.
- O. Discharging such other Medical Staff obligations as may be recommended by the Medical Executive Committee and approved by the Board.
- P. Participating in and completing the applicable Department orientation for new Practitioners.
- Q. Complying with Hospital health screening and immunization requirements (or be granted an exemption thereto) as set forth in the applicable Hospital policies and/or Medical Staff Policies.

2.5-2 Failure to satisfy any of the aforementioned responsibilities may be grounds for denial of Medical Staff reappointment and/or regrant of Privileges, or corrective action pursuant to these Bylaws.

2.6 Qualifications and Responsibilities of Practitioners Granted Medical Staff Appointment without Privileges

2.6-1 Practitioners requesting and/or granted Medical Staff appointment without Privileges shall satisfy the qualifications and responsibilities set forth in the applicable Medical Staff category and such other qualifications and responsibilities as recommended by the Medical Executive Committee and approved by the Board.

2.7 Process for Credentialing, Appointment/Reappointment, and Privileging

2.7-1 Except where the type of appointment and/or Privileges being granted allows for an alternative process as set forth in the Bylaws or the Credentials Policy (e.g., temporary Privileges), the process for credentialing, appointment/reappointment, and privileging shall be as follows:

- A. Applications for appointment, reappointment, and/or grant/regrant of Privileges shall be submitted to the Medical Staff Services Office who shall review each application for completeness and perform primary source verification.
- B. Upon completion of the collection and verification process, the completed application and all accompanying documents shall be reviewed by the applicable Department/Section Chief, the Surgeon-in-Chief, if applicable, the Chief Medical Officer, the Credentials Committee, and the Medical Executive Committee or as otherwise provided in accordance with the Bylaws and Credentials Policy.
- C. Initial appointments and reappointments to the Medical Staff and/or the granting/regranting of Privileges shall be made by the Board, or

as otherwise provided in accordance with the Bylaws or Credentials Policy.

- D. The Board shall act on appointments, reappointments, and/or Privileges only after there has been a recommendation from the Medical Executive Committee, unless otherwise authorized by these Bylaws or the Credentials Policy.
- E. The detailed procedures, with respect to Practitioners, for credentialing, for evaluating applications for initial appointment to the Medical Staff, for conducting appraisals for reappointment to the Medical Staff, and for the delineation, granting, and regranting of Privileges are outlined in the Credentials Policy.
- F. The detailed procedures, with respect to APPs, for credentialing and for the delineation, granting, and regranting of Privileges are outlined in the APP Policy.

2.8 Duration of Appointment and Privileges

- 2.8-1 Initial Medical Staff appointment and/or grant of Privileges, modification of Medical Staff appointment and/or Privileges, and Medical Staff reappointment and/or regrant of Privileges shall be for a period of not more than two (2) years.
- 2.8-2 A Medical Staff appointment and/or grant of Privileges for less than two (2) years shall not be deemed Adverse for purposes of the Medical Staff Bylaws or Policies.

2.9 Assessments and Dues

- 2.9-1 The Medical Executive Committee shall have the authority to determine the amount of Medical Staff assessments and annual dues.
- 2.9-2 Initial applicants will be assessed a non-refundable processing fee upon submitting an application for Medical Staff appointment and/or Clinical Privileges at the Hospital. Failure to pay such fee will be deemed a voluntary withdrawal of the application.
- 2.9-3 Annual Dues shall be paid by Members of the active and administrative Medical Staff categories. Payment of dues is to be submitted to the Medical Staff Services Office annually by December 31st.

ARTICLE III CLINICAL PRIVILEGES

3.1 In General

3.1-1 Every Practitioner and APP practicing at this Hospital shall, in connection with such practice, be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Board of Directors or as otherwise provided in the Credentials Policy or APP Policy, as applicable.

3.2 Temporary Privileges, Emergency Privileges, and Disaster Privileges

3.2-1 The procedures for granting Practitioners and APPs temporary Privileges, emergency Privileges, and disaster Privileges are set forth in the Credentials Policy or APP Policy, as applicable. Temporary privileges may be granted, if applicable, to a Practitioner providing telemedicine services at the Hospital.

3.2-2 Disaster Privileges may be granted to licensed volunteer Practitioners and Ohio APPs when the Hospital's emergency operations plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs. The CEO, CMO, or Medical Staff President may grant such disaster Privileges on a case-by-case basis in accordance with the requirements set forth in the Credentials Policy or APP Policy, as applicable.

3.3 Clinical Privileges – Practitioners

3.3-1 Every initial application for Medical Staff appointment and/or Privileges must contain a request for the particular Clinical Privileges, if any, desired by the applicant. The evaluation of such requests shall be based upon the qualifications set forth in Section 2.2-1 and an appraisal by the chief of the Department and/or Section in which such Privileges are sought. Each applicant must meet the appropriate Department and/or Section training requirements. The applicant shall have the burden of establishing his/her qualifications and current competency with respect to the Clinical Privileges he/she requests.

3.3-2 Clinical Privileges recommended for the Practitioner by the Department and/or Section Chief(s) shall be limited to the specific area(s) of expertise in which the Practitioner has completed training as delineated by the applicable national specialty board(s).

3.3-3 Periodic regrant of Clinical Privileges and the increase or curtailment of same shall be based upon, but not limited to, the direct observation of care provided, review of the records of patients treated in this Hospital, and review of the professional practice evaluation records of the Medical

Staff which document the evaluation of the Practitioner's participation in the delivery of medical/other professional care.

3.3-4 In order to obtain additional Clinical Privileges, a Practitioner shall make written application to the Medical Staff Services Office stating the additional Clinical Privileges desired and recent special training and experience in support thereof. Appropriate documentation must accompany the request. Such application shall be processed in accordance with the applicable procedure set forth in the Credentials Policy. In the event the requested additional Privileges are granted, such Privileges shall be subject to a Focused Professional Practice Evaluation period. In the event the requested additional Privileges are denied on an Adverse basis, the Practitioner shall be entitled to those procedural due process rights set forth in the Fair Hearing Policy.

3.4 Clinical Privileges – Podiatrists

3.4-1 Podiatrists may admit patients to the Hospital if granted Privileges to do so. Podiatrists must have made prior arrangements with a Physician Medical Staff Member with appropriate Privileges who is medically responsible for such patients' non-podiatric care. All patients admitted for podiatric care shall receive the same medical appraisal as other hospitalized patients. The Physician shall be responsible for completion and documentation of each such patient's medical history and physical examination and for providing any medical care that may be required at the time of admission or that may arise during hospitalization.

3.4-2 Podiatrists shall be responsible for the podiatric care of their patients including completion and documentation of each patient's podiatric history and physical examination and all appropriate elements of each patient's medical record.

3.4-3 Surgical procedures performed by Podiatrists shall be under the overall supervision of the Chief of the Department of Orthopedics. Podiatrists may write orders and prescribe medications within the limits of their licensure to the extent they are granted Clinical Privileges to do so and in accordance with the requirements set forth in the Medical Staff Bylaws and Policies.

3.5 Clinical Privileges - Psychologists

3.5-1 Psychologists may not admit or co-admit patients to the Hospital. Psychologists may treat only those patients who have been admitted by a Physician Medical Staff Member with admitting Privileges and must maintain a consultative relationship with the attending Physician during the course of treatment of the patient.

3.5-2 Psychologists shall be responsible for the psychological care of their patients including completion and documentation of each patient's psychological history and all appropriate elements of each patient's medical record. Psychological care provided by Psychologists must be under the supervision of the appropriate Section/Department Chief(s). Psychologists may practice within the limits of their licensure to the extent they are granted Privileges to do so and in accordance with the requirements set forth in the Medical Staff Bylaws and Policies.

3.6 Clinical Privileges – Dentists and Oral Maxillofacial Surgeons

3.6-1 Dentists may admit patients to the Hospital if granted Privileges to do so. Dentists must have made prior arrangements with a Physician Medical Staff Member with appropriate Privileges who is medically responsible for such patients' non-dental care. All patients admitted for dental care shall receive the same medical appraisal as other hospitalized patients. The Physician shall be responsible for completion and documentation of each such patient's medical history and physical examination and for providing any medical care that may be required at the time of admission or that may arise during hospitalization.

3.6-2 Dentists shall be responsible for the dental care of their patients including completion and documentation of each patient's dental history and physical examination and all appropriate elements of each patient's medical record.

3.6-3 Surgical procedures performed by Dentists shall be under the overall supervision of the Chief of the Department of Dentistry. Dentists may write orders and prescribe medications within the limits of their licensure to the extent they are granted Privileges to do so and in accordance with the requirements set forth in the Medical Staff Bylaws and Policies.

3.6-4 Oral Maxillofacial Surgeons may admit patients to the Hospital and may perform and document the admitting history and physical examination for his/her patients if granted Privileges to do so.

3.7 Professional Practice Evaluation

3.7-1 Practitioners granted Privileges at the Hospital shall exercise such Privileges consistent with accepted and prevailing standards of care.

3.7-2 The Hospital's focused professional practice evaluation ("FPPE") process shall be set forth in detail in the Practitioner/APP Effectiveness Policy and shall be implemented for all: (1) Practitioners requesting initial Privileges (2) existing Practitioners requesting additional Privileges during the course of a current appointment/Privilege period; and (3) in response to concerns regarding a Practitioner's ability to provide safe, quality patient care. The

FPPE period shall be used to determine the Practitioner's current clinical competence and ability to perform the requested Privileges.

- 3.7-3 Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all Practitioners with Privileges. The Hospital's OPPE process shall be set forth in detail in the Practitioner/APP Effectiveness Policy and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis.

**ARTICLE IV
PEER REVIEW FILES**

4.1 Peer Review Files

4.1-1 Information regarding peer review files is set forth in the Medical Staff Credentials Policy.

**ARTICLE V
PRACTITIONER CONDUCT AND IMPAIRMENT MATTERS**

5.1 Practitioner Conduct

5.1-1 Practitioners with Medical Staff appointment and/or Privileges at the Hospital are expected to conduct themselves in a professional and courteous way so as to reflect a respect for the rights of others and foster quality patient care and in accordance with the Medical Staff Practitioner/APP Effectiveness Policy. Actions of Practitioners that fall below accepted standards of professional conduct or courtesy will be considered misconduct and will not be tolerated. This shall include conduct which has the purpose or effect of interfering with an individual's work performance, interfering with Hospital activities, or creating an intimidating, hostile, or offensive work environment.

5.1-2 The procedure for addressing Practitioner conduct matters is set forth in the Medical Staff Practitioner/APP Professional Conduct Policy located in the Medical Staff Practitioner/APP Effectiveness Policy.

5.2 Practitioner Impairment

5.2-1 The procedure for addressing Practitioner/APP impairment is set forth in the Medical Staff Practitioner/APP Impairment Policy located in the Medical Staff Practitioner/APP Effectiveness Policy.

ARTICLE VI
COLLEGIAL INTERVENTION; CORRECTIVE ACTION; SUMMARY SUSPENSION;
AUTOMATIC SUSPENSION; AUTOMATIC TERMINATION

6.1 Informal Collegial Intervention

6.1-1 Collegial Intervention

- A. Prior to initiating corrective action against a Medical Staff Member for professional conduct or clinical competency concerns, the Vice President of the Medical Staff may elect, but is not obligated, to attempt to resolve the concern(s) informally.
- B. Any such informal/collegial attempts shall be documented and retained in the Medical Staff Member's quality file. If the person of concern is the Vice President of the Medical Staff, then the Medical Staff President shall be the appropriate person to attempt informal resolution.

6.1-2 No Obligation

- A. Nothing in this Section shall be construed as obligating the Hospital or Medical Staff leaders to engage in collegial intervention prior to implementing formal corrective action on the basis of a single incident.
- B. The Vice President of the Medical Staff/Medical Staff President, may in his/her discretion, involve other Medical Staff leaders and/or the Chief Medical Officer, to participate in the process and/or may delegate the process to a Department/Section Chief.
- C. Collegial intervention efforts may include review of documents and meetings with appropriate individuals, including the Practitioner of concern. All such collegial intervention activities, including implementation of any processes to resolve the problem (all of which must be voluntary), are documented in the Practitioner's quality file.
- D. The informal procedures described in this section will continue for as long as reasonable, generally not to exceed 120 days. If the informal procedures described in this section fail to resolve the concern to the satisfaction of the Vice President of the Medical Staff/Medical Staff President, a request for formal corrective action should be initiated.

6.2 Formal Corrective Action Procedure

6.2-1 Grounds for Corrective Action. Corrective action against a Medical Staff Member may be initiated whenever the Member acts, either within or outside the Hospital, in a manner that is or is reasonably likely to be:

- A. Contrary to the Medical Staff Bylaws, Policies, the Hospital's governing documents, or applicable Hospital policies and/or procedures.
- B. Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.
- C. Disruptive to Hospital operations.
- D. Damaging to the Medical Staff's or the Hospital's reputation.
- E. Below the applicable standard of care.

6.2-2 Authorization to Initiate. Any of the following may request that corrective action be initiated:

- A. An officer of the Medical Staff.
- B. The Medical Staff Member's Department/Section Chief
- C. MEC or any other standing Medical Staff committee (or chair thereof)
- D. Chief Executive Officer
- E. Chief Medical Officer
- F. Board or chair thereof

6.2-3 Initiation, Requests, Notices. All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. The request must include reference to the specific action(s) that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis for its recommendation in its minutes.

6.2-4 Investigation. Upon receipt of the request for corrective action, the MEC shall act on the request. The MEC may:

- A. Determine that no corrective action is warranted and close the matter.

- B. Determine that no corrective action is warranted and remand the matter for collegial intervention consistent with the Medical Staff governing documents.
 - C. Initiate a formal corrective action investigation in accordance with the requirements set forth in this §6.2.
- 6.2-5 A matter is under formal investigation upon the following events, whichever occurs first:
- A. The Medical Staff Member is notified by an authorized Hospital or MEC representative (either verbally or upon proof of receipt of Special Notice) that a request for corrective action has been submitted to the MEC.
 - B. The start of an MEC meeting at which a request for corrective action is being presented.
- 6.2-6 For the sole purpose of determining whether there is a potential reportable event, the matter is under formal corrective action until the end of the MEC meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under a formal corrective action investigation until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board.
- 6.2-7 The Medical Staff President shall provide the affected Practitioner with written notice of a determination by the MEC to go forward with a corrective action investigation. The Medical Staff Services Office shall notify the CMO, Department Chief, Section Chief, and (if applicable) the Surgeon-in-Chief of an MEC determination to go forward with a correction action investigation.
- 6.2-8 The MEC may conduct such investigation itself; assign the task to a Medical Staff officer, a Department Chief, or a standing or *ad hoc* committee of at least three Members; or, may refer the matter to the Board for investigation and resolution.
- 6.2-9 This investigative process is not a "hearing" as that term is used in the Fair Hearing Policy and shall not entitle the Medical Staff Member to the procedural rights provided in the Fair Hearing Policy.
- 6.2-10 The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with the Medical Staff Member involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or

group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved.

6.2-11 If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by minutes, to the MEC as soon as is practical after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action or no action at all (and the basis for such recommendations).

6.2-12 MEC Action. As soon as practical following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. Its action may include, without limitation, the following:

- A. A determination that no corrective action be taken.
- B. Issuance of a verbal warning or a letter of reprimand.
- C. Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision.
- D. Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member's ability to continue to exercise previously exercised Privileges for a period up to fourteen (14) days.
- E. Imposition of reduction, limitation/restriction, or suspension of all or any part of the Medical Staff Member's Privileges for a period up to fourteen (14) days.
- F. Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member's Privileges for a period up to fourteen (14) days.
- G. Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member's ability to continue to exercise previously exercised Privileges for a period in excess of fourteen (14) days.
- H. Recommendation of reduction, limitation/restriction, or suspension of all or any part of the Medical Staff Member's Privileges for a period in excess of fourteen (14) days.

- I. Recommendation of revocation of all or any part of the Medical Staff Member's Privileges.
- J. Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member's Privileges for a period in excess of fourteen (14) days.
- K. Referral to Board for action.

6.2-13 Effect of MEC Action

- A. The Practitioner shall be notified of the MEC's determination or recommendation.
- B. Adverse Recommendation. If the recommendation of the MEC is Adverse to the Medical Staff Member, the recommendation shall be forwarded to the Medical Staff President who shall promptly notify the affected Medical Staff Member, in writing, by Special Notice. The Medical Staff President shall then hold the MEC recommendation until the Medical Staff Member has exercised or waived the right to a hearing and appeal after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board for action.
- C. Referral to Board; Failure of MEC to Act. If the MEC (i) refers the matter to the Board for investigation; or (ii) fails to act on a request for corrective action within an appropriate time as determined by the Board, the Board may proceed with its own investigation or determination, as applicable to the circumstances. In the case of (ii), the Board shall make such determination after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.
 - (1) If the Board's decision is not Adverse to the Medical Staff Member, the action shall be effective as its final decision and the President of the Medical Staff shall inform the Medical Staff Member of the Board's decision by Special Notice.
 - (2) If the Board's decision is Adverse to the Medical Staff Member, the President of the Medical Staff shall inform the Medical Staff Member, by Special Notice, and the Medical Staff Member shall be entitled, upon timely and proper request, to the procedural rights set forth in the Fair Hearing Policy.

6.2-14 Other Action. The commencement of corrective action procedures against a Medical Staff Member shall not preclude the summary suspension,

automatic suspension, or automatic termination of the Medical Staff appointment and/or all, or any portion, of the Medical Staff Member's Privileges in accordance with the procedures set forth in Sections 6.3, 6.4, or 6.5.

6.3 Summary Suspension

6.3-1 Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect, or to reduce the substantial likelihood of injury or imminent danger to the life, health, or safety of any individual at the Hospital (*e.g.*, patient, employee, visitor, *etc.*), or may interfere with the safe and orderly operation of the Hospital, the following shall have the authority to summarily suspend the Medical Staff appointment and/or all, or any portion, of the Privileges of such Practitioner:

- A. Chief Medical Officer in consultation with the Medical Staff President
- B. Physician-in-Chief in consultation with the Chief Medical Officer and the Medical Staff President
- C. Surgeon-in-Chief in consultation with the Chief Medical Officer and the Medical Staff President
- D. Chief Executive Officer
- E. Board or Board chair
- F. MEC or Medical Staff President in consultation with the CMO

6.3-2 A summary suspension is effective immediately upon imposition. The person or group imposing the summary suspension shall immediately inform the President of the Medical Staff of the suspension and the President of the Medical Staff shall promptly give Special Notice thereof to the Practitioner. The Medical Staff President will also notify the CMO, the Surgeon-in-Chief, if applicable, and the Practitioner's Department Chief/Section Chief of the summary suspension to the extent an individual to be notified did not otherwise impose such summary suspension.

6.3-3 As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review and consider the need, if any, for corrective action pursuant to the procedure set forth in Section 6.2. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in the Fair Hearing Policy, even if the Practitioner involved attends the meeting, and no procedural requirements shall apply. The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board or the CEO.

- 6.3-4 In the case of a summary suspension imposed by the Board or CEO, the MEC shall give its recommendation to the Board/CEO as to whether such summary suspension should be modified, continued, or terminated. The Board/CEO may accept, modify, or reject the MEC's recommendation.
- 6.3-5 Not later than fourteen (14) days following the original imposition of the summary suspension, the Practitioner shall be advised, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board or the CEO, of the MEC's recommendation as to whether such summary suspension should be modified, continued, or terminated and of the Practitioner's rights, if any, pursuant to the Fair Hearing Policy.
- 6.3-6 A summary suspension that is lifted within fourteen (14) days of its original imposition on the grounds that the summary suspension was not required shall not be deemed an Adverse action for purposes of the Fair Hearing Policy.

6.4 Grounds for Automatic Suspension of Appointment and/or Privileges

6.4-1 The following events shall result in an automatic suspension or limitation of a Practitioner's Medical Staff appointment and/or Privileges, as applicable, without recourse to the procedural due process rights set forth in the Fair Hearing Policy.

A. License/Certificate to Practice

- (1) Whenever a Practitioner's license or certificate to practice is suspended, the Practitioner's Medical Staff appointment and Clinical Privileges shall be likewise automatically suspended as of the date such action becomes effective and throughout its term.
- (2) Whenever a Practitioner's license or certificate to practice is limited or restricted by the applicable licensing or certifying authority, the Practitioner's Medical Staff appointment and Clinical Privileges shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.
- (3) Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his/her Medical Staff appointment 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.

B. DEA Registration

- (1) In the event of action by the Drug Enforcement Administration (DEA) or other controlled substances authority suspending a Practitioner's DEA registration number the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended as of the date of such action and throughout its term.
- (2) In the event of action by the DEA or other controlled substances authority restricting or imposing probation on a Practitioner's DEA registration number the Practitioner's right to prescribe medications covered by the registration shall automatically and correspondingly be limited or made subject to the terms of the probation as of the date of such action and throughout its term.

C. Professional Liability Insurance. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Practitioner's appointment and Privileges shall be automatically suspended until Professional Liability Insurance coverage is restored or the matter is otherwise resolved pursuant to Section 6.5-1 (C). The Medical Staff Services Office shall be provided with a copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the Practitioner's non-compliance with the Hospital's Professional Liability Insurance requirements, any limitation on the new policy, and a summary of relevant activities during the period of non-compliance. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this provision.

D. Documentation of TB Test. Failure to adhere to tuberculosis screening requirements as set forth in the Hospital's Tuberculosis Exposure Control Plan shall result in automatic suspension of the Practitioner's Medical Staff appointment and Privileges.

E. Delinquent Medical Records. Whenever a Practitioner fails to complete medical records as provided for in applicable Hospital/Medical Staff policies, the Practitioner's Privileges shall be automatically suspended or limited to the extent and in the manner provided for in such Hospital/Medical Staff policies.

F. Federal Healthcare Program. Whenever a Practitioner is suspended from participating in a Federal Healthcare Program, the

Practitioner's appointment and Privileges shall be likewise immediately and automatically suspended.

- G. Failure to Pay Medical Staff Dues. Failure to render payment of Medical Staff dues by December 31st, unless otherwise waived by the MEC in cases of undue hardship, shall result in an automatic suspension of the Practitioner's appointment and Privileges.
- H. Investigations, Charges, Indictment. At such time as the Hospital learns through a reliable source that a Practitioner is under investigation by a federal, state, or local law enforcement agency or has been charged or indicted for a violent crime, a crime against a child, or improper prescribing of a controlled substance, the Practitioner's Privileges will be automatically suspended.
- I. Immunizations/Health Screenings. Failure to provide documentation of required immunizations and/or health screenings (or an approved exemption) in accordance with the requirements set forth in the applicable Hospital policies and/or Medical Staff Policies will result in an automatic suspension of the Practitioner's Medical Staff appointment and/or Privileges subject to Section 6.5-1(G) below.

6.4-2 Impact of Automatic Suspension or Limitation of Medical Staff Appointment and/or Privileges

- A. With the exception of Section 6.4-1 (E) regarding delinquent medical records, during such period of time when a Practitioner's appointment and/or Privileges are automatically suspended or limited, he/she may not, as applicable, exercise his/her Medical Staff appointment or any Privileges at the Hospital including, but not limited to, participating in on-call coverage, scheduling surgery, admitting patients, or otherwise providing professional care, treatment, and/or services at the Hospital.
- B. A Practitioner whose Privileges are automatically suspended or limited pursuant to Section 6.4-1 (E) for delinquent medical records is subject to the same limitations except that such Practitioner may:
 - (1) Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension/limitation of Privileges.
 - (2) Attend to the management of patients under his or her care requiring emergency care and intervention.
 - (3) Attend to the management of any patient under his/her care whose admission or outpatient procedure was scheduled

prior to the effective date of the automatic suspension and which occurs within forty-eight (48) hours after the automatic suspension.

6.4-3 Action Following Imposition of Automatic Suspension

- A. At its next regular meeting (or sooner if the Medical Executive Committee deems it appropriate) after the imposition of an automatic suspension, the Medical Executive Committee shall convene to determine if corrective action is necessary in accordance with the procedure set forth in Section 6.2.
- B. The lifting of the action or inaction that gave rise to an automatic suspension of Medical Staff appointment and/or Privileges shall result in the automatic reinstatement of the Practitioner's appointment and/or Privileges, as applicable; provided, however, that the Practitioner shall be obligated to provide such information/documentation as the Medical Staff Services Office may reasonably request to assure that the situation that gave rise to the automatic suspension/limitation has been appropriately resolved and that all information in the Practitioner's credentials file is current.
- C. Written notification of an automatic suspension and of reinstatement of Medical Staff appointment and Privileges following an automatic suspension shall be given to the affected Practitioner by the Medical Staff President or Chief Medical Officer. The Medical Staff Services Office will notify, as applicable, the Medical Staff President, CMO, Surgeon-in-Chief, and the Practitioner's Department Chief/Section Chief of an automatic suspension of the Practitioner's Medical Staff appointment and/or Clinical Privileges and the automatic reinstatement thereof.

6.5 Automatic Termination of Medical Staff Appointment and Privileges

6.5-1 Imposition of Automatic Termination. The following events shall result in an automatic termination of appointment and Privileges without recourse to the procedural due process rights set forth in the Fair Hearing Policy.

- A. Licensure. Action by any applicable licensing authority terminating a Practitioner's professional license shall result in the automatic termination of the Practitioner's Medical Staff appointment and Privileges.
- B. DEA Registration. In the event of action by the DEA or other controlled substances authority revoking a Practitioner's DEA registration number, the Practitioner's Medical Staff appointment and Privileges shall automatically terminate.

- C. Professional Liability Insurance. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect for a period greater than thirty (30) days, the Practitioner's Medical Staff appointment and Privileges shall automatically terminate as of the thirty-first (31st) day. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.
- D. Federal Healthcare Program. Whenever a Practitioner is excluded from participating in a Federal Healthcare Program, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.
- E. Plea of Guilty to Certain Offenses. If a Practitioner pleads guilty or no contest to, or is found guilty of a felony or other serious offense that involves (i) violence or abuse upon a person, conversion, embezzlement or misappropriation of property; (ii) fraud, bribery, evidence tampering or perjury; (iii) a drug offense; or (iv) as otherwise required by Ohio law, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.
- F. Failure to Pay Medical Staff Dues. Failure to pay Medical Staff dues following an automatic suspension, by March 1st, shall result in automatic termination of the Practitioner's Medical Staff appointment and Privileges.
- G. Immunizations/Health Screenings. In the event that documentation of required immunizations and/or health screenings (or an approved exemption) is not provided within sixty (60) days following the date of an automatic suspension of Medical Staff appointment and/or Privileges pursuant to Section 6.4-1(I), then the Practitioner's Medical Staff appointment and/or Privileges shall automatically terminate as of the sixty-first (61st) day.

6.5-2 The Medical Staff Services Office will notify, as applicable, the Medical Staff President, CMO, Surgeon-in-Chief, and the Practitioner's Department Chief/Section Chief of an automatic termination of the Practitioner's Medical Staff appointment and/or Clinical Privileges.

6.6 Alternate Medical Coverage

Immediately upon the imposition of a summary suspension, automatic suspension, or automatic termination, the Chief Medical Officer, after consultation with the applicable Department Chief, shall have authority to provide for alternative medical coverage for the patients of the Practitioner who remain in the Hospital at the time of such summary suspension or automatic suspension/termination. The wishes of

the patients shall be considered, when feasible, in the selection of such alternative Practitioner. The affected Practitioner shall confer with the covering Practitioner to the extent necessary to safeguard the patient(s).

6.7 Consistency of Action Between Hospital and Affiliate Hospital(s)

6.7-1 So that there is consistency between the Hospital and Affiliate Hospital(s) regarding corrective action and the status of medical staff appointment and privileges considering that the Hospital and the Affiliate Hospital(s) are part of the same healthcare system and that the Hospital and the Affiliate Hospital(s) have agreed to share information regarding appointment and privileges, the following automatic actions shall occur:

- A. With the exception of an automatic suspension for delinquent medical records, if a Practitioner's appointment and/or Privileges are automatically suspended or automatically terminated, in whole or in part, at Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy.
- B. If a Practitioner's appointment and/or privileges are summarily suspended or if a Practitioner voluntarily agrees not to exercise privileges while undergoing an investigation at Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the Practitioner's appointment and/or Privileges at Hospital and shall remain in effect until such time as Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.
- C. If a Practitioner's appointment and/or privileges are limited, suspended, or terminated at Affiliate Hospital(s), in whole or in part, based on professional conduct or clinical competency concerns, the Practitioner's appointment and/or Privileges at Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy unless otherwise provided in the final decision at Affiliate Hospital(s).
- D. If a Practitioner resigns his/her medical staff appointment and/or privileges or fails to seek reappointment and/or regrant of privileges at Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the Practitioner's Medical Staff appointment and/or Privileges at Hospital without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy.

- E. If a Practitioner withdraws an initial application for medical staff appointment and/or privileges at Affiliate Hospital(s) for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to applications for Medical Staff appointment and/or Privileges at Hospital without recourse to the procedural due process rights set forth in these Bylaws and the Fair Hearing Policy.

ARTICLE VII HEARINGS

- 7.1** Unless otherwise provided in the Medical Staff Bylaws or Policies, when a Practitioner receives notice of an Adverse recommendation of the MEC, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in the Fair Hearing Policy.
- 7.2** Unless otherwise provided in the Medical Staff Bylaws or Policies, when a Practitioner receives notice of an Adverse recommendation or action of the Board, and such decision is not based upon a prior Adverse recommendation of the MEC with respect to which the Practitioner was entitled to a hearing, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in the Fair Hearing Policy.
- 7.3** Upon receipt of a timely and proper request therefore, a hearing shall be scheduled by the Medical Staff President, if the request for hearing was prompted by an Adverse recommendation of the MEC; or, by the Board chair, if the request for hearing was prompted by an Adverse recommendation or action of the Board.
- 7.4** The hearing shall be conducted by either a hearing officer or a hearing panel, as determined by the body whose Adverse recommendation or action triggered the request for the hearing.
- 7.4-1 A hearing officer may be a Practitioner, an individual from outside the Hospital, such as an attorney, or other individual qualified to conduct the hearing. The hearing officer is not required to be a Medical Staff Member.
- 7.4-2 A hearing panel shall consist of not less than three (3) individuals. The panel members may either be Practitioners, individuals from outside of the Hospital, or a combination thereof.
- 7.4-3 The hearing shall be conducted in a manner consistent with the then current requirements of the Health Care Quality Improvement Act, as amended from time to time, and as further detailed in the Fair Hearing Policy.

**ARTICLE VIII
MEDICAL STAFF OFFICERS**

8.1 Officers of the Medical Staff

8.1-1 The elected officers of the Medical Staff shall be:

- A. President
- B. Vice-President
- C. Immediate Past President

8.1-2 The President shall be nominated to become Immediate Past President immediately following his or her term as President. In the event the incumbent President does not desire to become Immediate Past President, then the Nominating Committee shall nominate another Medical Staff Member who has previously held the office of President to serve as a replacement Immediate Past President for election by the voting Members of the Medical Staff.

8.2 Qualifications of Medical Staff Officers

8.2-1 Officers must be Members of the active Medical Staff in Good Standing at the time of nomination and election and must remain active Members in Good Standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

8.2-2 Elected officers are expected to facilitate communication and joint decision-making with each other as well as the Hospital Administration in matters of mutual concern.

8.2-3 Elected officers must attend one continuing education program related to Medical Staff leadership and/or credentialing functions during their term of office.

8.2-4 The CEO (if a Practitioner), Chief Medical Officer, Administrative Medical/Surgical Directors, Physician-In-Chief, Surgeon-In-Chief, and the Department Chiefs of Pediatrics and Pediatric Surgery are not eligible for election as Medical Staff officers.

8.3 Election of Medical Staff Officers

8.3-1 Officers shall be elected by a majority vote of the voting Members of the Medical Staff.

- 8.3-2 The Nominating Committee shall consist of the Chief Medical Officer and the five (5) most recent past Medical Staff Presidents with the Immediate Past President acting as chairperson of the committee.
- 8.3-3 The current Medical Staff President will serve as a consultant to the Nominating Committee and will not be a voting member when selecting the nominees for the slate of Medical Staff officers and elected at-large representatives to the Medical Executive Committee.
- 8.3-4 The Nominating Committee shall receive and consider names of active Medical Staff Members in Good Standing for the offices of President, Vice President, and Immediate Past President. The Nominating Committee will maintain a balance of leadership representation alternating between medical and surgical specialties for Medical Staff President and Vice-President.
- 8.3-5 The nominees for the offices of President, Vice-President, and Immediate Past President shall be submitted to the Medical Executive Committee for information.
- 8.3-6 The Nominating Committee's nominees for the offices of President, Vice-President, and Immediate Past President shall be submitted to the voting Members of the Medical Staff for vote.

8.4 Term of Office

Each elected Medical Staff officer shall serve a two-year term commencing on the first day of January of the year following the election. Each officer shall serve until the end of his/her term or until a successor is elected unless the officer sooner resigns or is removed from office. A Practitioner may be re-elected for additional terms of office.

8.5 Duties of Medical Staff Officers

- 8.5-1 President: The President shall serve as the principal elected officer of the Medical Staff. The duties of the Medical Staff President shall include, but not be limited to, the following:
- A. Acting in coordination and cooperation with the Chief Executive Officer and Chief Medical Officer in all matters of mutual concern within the Hospital.
 - B. Serving as chairperson and being responsible for the agenda of all Medical Staff meetings and minutes.
 - C. Serving as chairperson, voting member, and being responsible for the agenda of all Medical Executive Committee meetings and minutes.

- D. Serving as a voting member of the Board Joint Conference Committee and any Medical Staff, Hospital, or Board committees to which he/she has been appointed.
- E. Being responsible for the enforcement of the Medical Staff Bylaws and Policies; for implementation of sanctions where indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Member.
- F. Appointing, with notification to the Chief Medical Officer, the chairperson and Medical Staff members to all standing, and multidisciplinary Medical Staff committees except the Medical Executive Committee and the Board Joint Conference Committee; and, receiving notification from the Chief Medical Officer of appointment of Medical Staff Members to integrated Hospital committees.
- G. Representing the views, policies, needs, and concerns of the Medical Staff to the Chief Medical Officer, Chief Executive Officer, and Board of Directors.
- H. Being the spokesperson for the Medical Staff in its external professional and public relations.
- I. Serving as an *Ex-Officio* member of the Board of Directors and its executive committee; making recommendations to the Board of Directors regarding appointments, reappointments, granting/re-granting of Privileges, and other Medical Staff business.

8.5-2 Vice-President. The duties of the Medical Staff Vice-President are as follows:

- A. In the absence of the President, he/she shall assume all the duties and have the authority of the President.
- B. Serving as a voting member of the Hospital Quality Improvement Committee, Chief Medical Officer Advisory Committee, Bylaws Committee, Credentials Committee, and the Medical Executive Committee.
- C. Serving as a voting member of the Board Joint Conference Committee and any Medical Staff, Hospital, or Board committees to which he/she has been appointed.
- D. Creating the Medical Staff budget in consultation with the Manager of the Medical Staff Services Office and the other Medical Staff officers.

- E. Automatically succeeding the President when the latter fails to serve for any reason. He/she shall carry out the duties of the President as specified herein.
- F. Performing additional duties as may be assigned by the Medical Staff President.
- G. Being responsible for assisting the Medical Staff President in the enforcement of the Medical Staff Bylaws and Policies.

8.5-3 Immediate Past-President. The duties of the Immediate Past Medical Staff President are as follows:

- A. Serving as an advisory and voting member of the Medical Executive Committee to provide continuity with respect to discussions, actions, and programs implemented during his/her term as President.
- B. Serving as chairperson of the Nominating Committee.
- C. Serving as chairperson of the Bylaws Committee and assisting the Medical Staff officers in creating and revising the Medical Staff Bylaws and Policies.
- D. Serving as a voting member of the Hospital Quality Improvement Committee, Chief Medical Officer Advisory Committee, and Credentials Committee.
- E. Serving as a voting member of the Board Joint Conference Committee and any Medical Staff, Hospital, or Board committees to which he/she has been appointed.
- F. Developing and maintaining programs for Practitioners and Advanced Practice Providers in partnership with relevant Hospital departments (e.g. orientation, mentoring, and wellness).
- G. Serving as the OPPE and FPPE consultant for the Medical Staff.
- H. Performing additional duties as may be assigned by the Medical Staff President.
- I. Being responsible for assisting the Medical Staff President in the enforcement of the Medical Staff Bylaws and Policies.

8.6 Compensation for Medical Staff Officers

The elected officers of the Medical Staff (President; Vice-President; Immediate Past President) shall be compensated for their services with funds derived from

the Medical Staff activities fund. The amount of compensation shall be determined by the Medical Executive Committee.

8.7 Vacancies in Office

Vacancies in office during the Medical Staff Year, except for the Presidency, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the President, the Vice-President shall serve out the remaining term.

8.8 Resignation and Removal of Medical Staff Officers

8.8-1 A Medical Staff officer may resign at any time by giving written notice to the MEC. Such resignation shall take effect on the date of the MEC's receipt of the notice or at any later time specified in such notice.

8.8-2 Any officer may be removed from his or her position by an affirmative vote of two-thirds of the voting Medical Staff Members present at a special meeting of the Medical Staff called for that purpose. Written notification of the meeting at which removal is to be considered, and the basis for the action, shall be submitted to the voting Medical Staff Members at least 10 days prior to the meeting. The officer will be afforded the opportunity to speak on his/her own behalf before a vote is taken. Removal may be based upon failure to perform the duties of the position held as described in these Medical Staff Bylaws or other reasons deemed sufficient by the voting Medical Staff Members including, but not limited to:

- A. Failure to continuously satisfy the qualifications for the office with the exception that failure to remain an active Member of the Medical Staff in Good Standing during his/her term of office shall immediately create a vacancy in the office involved.
- B. The imposition of a summary suspension, an automatic suspension, or corrective action taken against the officer that results in a final Adverse decision.
- C. Conduct or statements detrimental to the interests of the Medical Staff or Hospital or to their goals, programs, or public image.
- D. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office.

8.8-3 Imposition of an automatic termination of Medical Staff appointment and Privileges shall result in an automatic removal of the Medical Staff officer from his/her office.

8.9 Representative to the American Medical Association/Organized Medical Staff Section

- 8.9-1 The representative to the American Medical Association/Organized Medical Staff Section shall be held by one representative for a three year period unless the representative sooner resigns or is removed from the position. The representative will be appointed to the position by the officers of the Medical Staff.
- 8.9-2 The representative shall be a Member of the Medical Staff in Good Standing who may or may not be a member of the Columbus Medical Association.
- 8.9-3 The duties of the representative shall include, but not be limited to, acting as a liaison in the political aspects of local, state, and national Medical Staff issues.
- 8.9-4 The representative may resign at any time by giving written notice to the Medical Staff President. Such resignation shall take effect on the date of the Medical Staff President's receipt of the notice or at any later time specified in such notice.

**ARTICLE IX
MEDICAL STAFF DEPARTMENTS AND SECTIONS**

9.1 Medical Staff Departments & Sections

9.1-1 The Medical Staff has a formalized organizational structure made up of Departments and Sections as set forth in the Organizational Policy. Each Department and Section shall be organized as a separate part of the Medical Staff and shall have a chief whose functions are described in the Bylaws and Organizational Policy.

9.2 Qualifications of Medical Staff Department Chiefs & Section Chiefs

9.2-1 Each Department Chief and Section Chief shall be a Member of the active Medical Staff with Privileges (except that an active Medical Staff Member without Privileges may serve as the Section of Community Pediatrics) and a member of the applicable Department/Section; remain in Good Standing throughout his/her term; and be willing and able to faithfully discharge the functions of his/her position.

9.2-2 Department Chiefs and Section Chiefs shall be well qualified by training, experience, and demonstrated ability for the position. It is imperative that these Practitioners be child care specialists with their primary activities, interests, and concerns being in the area of teaching, patient care, and research at the Hospital.

9.2-3 Department Chiefs and Section Chiefs shall be certified by an appropriate specialty board or demonstrate comparable competence affirmatively established through the Medical Staff credentialing process.

9.3 Duties of Medical Staff Department Chiefs & Section Chiefs

9.3-1 In addition to the roles and responsibilities set forth in the Organizational Policy, each Department Chief/Section Chief shall be responsible for the following:

- A. Overseeing the clinically related activities of the Department/Section.
- B. Overseeing the administratively related activities of the Department/Section unless otherwise provided by the Hospital.
- C. Continuing surveillance of the professional performance of all Practitioners and APPs in the Department/Section who have delineated Clinical Privileges.

- D. Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department/Section.
- E. Recommending Clinical Privileges for each member of the Department/Section.
- F. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department/Section or the organization.
- G. Integration of the Department/Section into the primary functions of the organization.
- H. Coordination and integration of interdepartmental and intradepartmental services.
- I. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- J. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
- K. Determination of the qualifications and competence of Department/Section personnel who are not Practitioners and who provide patient care, treatment, and services.
- L. Continuous assessment and improvement of the quality of care, treatment, and services.
- M. Maintenance of quality control programs, as appropriate.
- N. Orientation and continuing education of all persons in the Department/Section.
- O. Recommending space and other resources needed by the Department/Section.
- P. Such other duties as may be set forth in the Medical Staff Organizational Policy.

9.4 Additional Information Regarding Department Chiefs & Section Chiefs

9.4-1 Additional details regarding Medical Staff Department Chiefs & Section Chiefs including, but not limited to, the procedure for selecting and removal of Department/Section Chiefs is set forth in the Medical Staff Organizational Policy.

**ARTICLE X
MEDICAL STAFF COMMITTEES**

10.1 Medical Executive Committee

10.1-1 Composition: The Medical Executive Committee shall consist of representatives of the active and administrative Medical Staff and administration.

- A. The Medical Executive Committee shall be a standing committee of the Medical Staff and shall consist of the following voting members:
- (1) Medical Staff President who shall serve as chair
 - (2) Medical Staff Vice President
 - (3) Medical Staff Immediate Past President
 - (4) Chief Executive Officer
 - (5) Chief Medical Officer
 - (6) Physician-in-Chief
 - (7) Surgeon-in-Chief
 - (8) Administrative Medical Director
 - (9) One (1) at-large representative (who is an active Medical Staff Member with Privileges) appointed and able to be removed by the Medical Staff President (2 year term)
 - (10) Two (2) medical representatives at-large at least one of whom is a community practicing general pediatrician (elected pursuant to subsection (F) for a 2 year term); the next highest vote recipient will be the designated alternate as needed
 - (11) Two (2) surgical representatives at-large (elected pursuant to subsection (F) for a 2 year term); the next highest vote recipient will be the designated alternate as needed
- B. The Chief Operating Officer, Chief Nursing Officer, at-large representative alternates, the Hospital's APP Director, and such other guests as the MEC deems appropriate may attend MEC meetings; provided, however, that such individuals shall not have the right to vote on MEC matters unless he/she is otherwise serving as the designee of a voting MEC member.

- C. In case of an expected absence, it will be the responsibility of the elected at-large representative to contact the appropriate designated alternate in a timely manner to represent him/her at the Medical Executive Committee meeting. The alternate shall have all the rights of the absent member. Anticipated absences of any MEC members should be conveyed to the Medical Staff Services Office.
- D. Should an at-large elected member of the Medical Executive Committee decide to step-down from the Medical Executive Committee, then the alternate will become an at-large member of the Medical Executive Committee for the remainder of the (2) two year term and the next highest vote recipient will become the new alternate.
- E. Any at-large representative may be removed from an elected position by an affirmative vote of two-thirds of the voting members of the Medical Executive Committee present at any regular or special meeting of the MEC.
 - (1) Written notification of the MEC meeting at which removal is to be considered, and the basis for the action, shall be submitted to the voting MEC members at least ten (10) days prior to the meeting. The elected MEC at-large representative will be afforded the opportunity to speak on his/her own behalf before a vote is taken. Removal may be based upon failure to perform the duties of the position held as described in these Medical Staff Bylaws or other reasons deemed sufficient by the Medical Executive Committee including, but not limited to:
 - (a) Failure to continuously satisfy the qualifications for the position with the exception that failure to remain an active Member of the Medical Staff with Privileges in Good Standing during the term of his/her position shall immediately create a vacancy in the position involved.
 - (b) The imposition of a summary suspension, an automatic suspension, or corrective action taken against the elected MEC at-large representative that results in a final Adverse decision.
 - (c) Conduct or statements detrimental to the interests of the Medical Staff or Hospital or to their goals, programs, or public image.

- (d) Physical or mental infirmity that renders the elected MEC at-large representative incapable of fulfilling the duties of his/her position.
 - (2) Imposition of an automatic termination of Medical Staff appointment and Privileges shall result in an automatic removal of the MEC at-large representative from his/her position.
- F. The elected at-large members of the Medical Executive Committee must be active Medical Staff Members with Privileges and shall be nominated and elected for a two (2) year term in the same manner and at the same time as the nomination and election of the Medical Staff officers.
- G. The MEC members set forth in Section 10.1-1 (A)(1) through (A)(8) above shall be selected and removed from the Medical Executive Committee only as the person who holds each respective position changes in accordance with the Bylaws or applicable Hospital/Medical Staff policies.
 - (1) Selection, resignation, and removal of Medical Staff officers is addressed in Article VIII of these Bylaws.
 - (2) Selection, resignation, and removal of the Administrative Medical Director is addressed by the CMO.
 - (3) Selection, resignation, and removal of Department Chiefs is addressed in Article IX of these Bylaws and the Medical Staff Organizational Policy.
 - (4) Selection, resignation, and removal of the Physician-in-Chief and Surgeon-in-Chief are addressed in the Medical Staff Organization Policy.
 - (5) Selection, resignation, and removal of the Hospital CEO and CMO is addressed by the Board.
- H. To the extent eligible under these Bylaws, active and administrative Medical Staff Members of any discipline or specialty may serve on the Medical Executive Committee. At all times, Physician Members of the active Medical Staff with Privileges shall comprise at least a majority of the elected and appointed voting members of the Medical Executive Committee.
- I. Guests may be invited to attend designated meetings of the Medical Executive Committee to provide periodic reports as

determined by the officers of the Medical Staff in consultation with the Chief Medical Officer and Chief Executive Officer.

10.1-2 Duties. The Medical Executive Committee shall:

- A. Represent and act on behalf of the Medical Staff between Medical Staff meetings subject to such limitations as may be imposed by these Bylaws, Medical Staff/Hospital policies, and by the Hospital's Code of Regulations.
- B. Coordinate the activities of the various Medical Staff Departments and/or Sections.
- C. Receive and act on reports and recommendations from Medical Staff committees, Departments and/or Sections, and assigned activity groups. The Medical Executive Committee will delegate appropriate business to committees while retaining the right of executive responsibility and authority over all Medical Staff committees.
- D. Implement policies of the Medical Staff not otherwise the responsibility of the Departments and/or Sections.
- E. Serve as a liaison between the Medical Staff and the Chief Medical Officer, Chief Executive Officer, and the Board of Directors.
- F. Recommend action to the Chief Medical Officer and Chief Executive Officer on matters of a medical-administrative nature including the quality aspects of contracts for patient care services.
- G. Fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to the patients in the Hospital. The Medical Executive Committee shall have access to the Board of Directors through the President of the Medical Staff, the Chief Medical Officer, the Chief Executive Officer, the Joint Conference Committee, and through its committee minutes.
- H. Ensure that the Medical Staff is kept abreast of the Hospital's accreditation program and informed of the accreditation status of the Hospital.
- I. Review and act on the recommendations of the Credentials Committee including:
 - (1) Reviewing the credentials of all applicants and making recommendations for Medical Staff appointment, assignment to Departments/Sections, and delineation of Clinical Privileges.

- (2) Periodically reviewing all information available regarding the performance and clinical competence of Members and other Practitioners/APPs with Clinical Privileges and, as a result of such reviews, making recommendations for, as applicable, reappointments and/or regrant or changes in Clinical Privileges.
 - (3) Taking all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of all Practitioners and Advanced Practice Providers including the initiation of and/or participation in Medical Staff corrective action or review measures when warranted and implementation of any actions taken as a result thereof.
- J. Report at Medical Staff meeting all actions affecting the Medical Staff.
 - K. Make recommendations with respect to Medical Staff Departments, Sections, and Medical Staff committees.
 - L. Create and, through the President of the Medical Staff, appoint special Medical Staff committees when the need arises. The special Medical Staff committee shall receive a specific task to perform, shall be in existence for a designated period of time, and shall have its duties outlined in detail.
 - M. Make recommendations regarding medical policy decisions, Medical Staff policy changes, or interdepartmental relationships, and act as a mediator in disputes arising between Departments, Sections, Practitioners, and/or Hospital or Medical Staff administration.
 - N. Inform the Medical Staff of significant actions taken which affect them during the period between Medical Staff meetings.
 - O. Review quality indicators to promote uniformity regarding patient care services.
 - P. Provide leadership in activities related to patient safety.
 - Q. Provide oversight in the process of analyzing and improving patient satisfaction.
 - R. Make recommendations to the Board of Directors regarding Medical Staff structure; participation of the Medical Staff in performance Improvement, quality assessment, and utilization review activities; and mechanisms for Privileges delineation, credentials

review, termination of Medical Staff appointment and/or Privileges, and fair hearing procedures.

- S. Organize the Medical Staff's performance improvement/quality assessment, quality review, and utilization management activities and establish a mechanism to conduct, evaluate, and revise such activities after consultation with the appropriate Department or Section Chief.
- T. Request evaluation of Practitioners and Advanced Practice Providers privileged through the Medical Staff process in instances where there is doubt about the Practitioner's or Advanced Practice Provider's ability to perform the Privileges requested.
- U. Make recommendations to the Board regarding the Medical Executive Committee's review of and actions on reports of Medical Staff committees, Departments, Sections and other assigned activity groups.
- V. Adopt and amend Medical Staff Policies in accordance with the procedure set forth in Article XIII of these Bylaws.

10.1-3 Meetings: The Medical Executive Committee shall meet not less than ten (10) times per year and maintain minutes which shall be distributed to each committee member and to the Board of Directors.

10.2 Other Standing Medical Staff Committees

10.2-1 The composition, duties, and meeting requirements regarding other standing Medical Staff committees are set forth in the Medical Staff Organizational Policy.

**ARTICLE XI
CATEGORIES OF THE MEDICAL STAFF**

11.1 The Medical Staff

The Medical Staff shall consist of the following categories: Active with Privileges, Active without Privileges, Administrative, Consulting, Retired, Emeritus, Honorary, and Affiliate.

11.2 The Active Medical Staff

11.2-1 Category I: Active Medical Staff without Privileges

- A. The active Medical Staff without Privileges shall consist of those credentialed Practitioners who are not requesting Clinical Privileges but want to participate in various functions throughout the Hospital. Active Medical Staff Members without Privileges shall satisfy the qualifications set forth in Section 2.2-1 unless otherwise recommended by the Medical Executive Committee and approved by the Board.
- B. Active Medical Staff Members without Privileges are required to pay annual Medical Staff dues.
- C. Active Medical Staff Members without Privileges may:
 - (1) Have view only access (no order writing, *etc.*) to the electronic health care records of patients in their practice.
 - (2) Teach, in a classroom setting, House Staff assigned by the Section/Department Chief.
 - (3) Vote on any matters pertaining to Medical Staff business including, but not limited to, the election of Medical Staff officers; at-large representatives on the Medical Executive Committee; and amendments to the Medical Staff Bylaws.
 - (4) Contribute to the organizational, administrative, and/or business matters of the Medical Staff and Hospital.
 - (5) Attend educational programs of the Medical Staff and Hospital.
 - (6) Receive publications and communications of the Medical Staff and Hospital.
 - (7) Serve as a committee member or chair and vote on matters of Medical Staff and Hospital committees of which he/she is

a member; provided, however, that an active Medical Staff Member without Privileges may not serve as an MEC at-large representative.

- (8) Serve as a Medical Staff officer but may not serve as a Department/Section Chief except an active Medical Staff Member without Privileges may serve as the Section of Community Pediatrics.
- (9) Attend Medical Staff and Hospital social functions.
- (10) Attend Medical Staff meetings and those Department/Section and committee meetings of which he/she is a member.
- (11) Vote on matters of the Department/Section of which the Practitioner is a member.
- (12) Not be granted Privileges.

11.2-2 Category II: Active Medical Staff with Privileges

A. The active Medical Staff with Privileges shall consist of those credentialed Practitioners who conduct a significant portion of their professional activity at the Hospital, admit patients, and exercise such Clinical Privileges as are granted specific to their specialty and who are able to provide continuous quality care to their pediatric patients. Active Medical Staff Members with Privileges shall meet **ONE** of the following criteria.

- (1) Have ten (10) or more Patient Encounters at the Hospital during each two (2) year appointment/Privilege period. If a Practitioner fails to meet the Patient Encounter requirements following completion of two consecutive appointment/Privilege periods, the Practitioner will be transferred to another Medical Staff category for which he/she is eligible, if any, in the absence of a showing, satisfactory to the MEC and Board, that this was due to unusual circumstances unlikely to occur in the next appointment/Privilege period; **OR,**
- (2) Teach and supervise medical/dental students and/or House Staff in Hospital inpatient areas, outpatient clinics/services, or community-based offices and clinics, including through telemedicine.

B. The active Medical Staff with Privileges shall do the following:

- (1) Pay annual Medical Staff dues.
- (2) Complete Zero Hero training or other similar training programs approved by the Chief Medical Officer within three (3) months of initial appointment unless additional time or an exception is granted by the Chief Medical Officer and Medical Staff President.
- (3) Be expected to attend Medical Staff and those Department/Section and committee meetings of which he/she is a member unless otherwise excused.
- (4) Attend patients regardless of their ability to pay, as required, consult with other Practitioners consistent with his/her scope of practice, and serve on the on-call roster for the purpose of assignment to patients who do not have an attending Practitioner.

C. Category II active Medical Staff Members with Privileges may:

- (1) Teach and supervise House Staff assigned by the Department/Section Chief.
- (2) Vote on any matters pertaining to Medical Staff business including, but not limited to, the election of Medical Staff officers; at-large representatives on the Medical Executive Committee; and amendments to the Medical Staff Bylaws.
- (3) Attend educational programs of the Medical Staff and Hospital.
- (4) Receive publications and communications of the Medical Staff and Hospital.
- (5) Serve as a committee member or chair and vote on Medical Staff and Hospital committees of which he/she is a member.
- (6) Contribute to the organizational, administrative, and/or business matters of the Medical Staff and Hospital.
- (7) Serve as a Medical Staff officer or Department/Section Chief.
- (8) Attend Medical Staff and Hospital social functions.
- (9) Exercise the Privileges granted including, but not limited to, the ability to admit patients to the Hospital.

- (10) Vote on matters of the Department/Section of which he/she is a member.

11.3 The Administrative Medical Staff

11.3-1 The administrative Medical Staff category may be held by any Practitioner with no clinical responsibilities and who is employed by the Hospital to perform ongoing administrative responsibilities. This may include medical administrative appointments, research administrators, the Chief Executive Officer, the Chief Medical Officer, and others as deemed appropriate by the MEC.

- A. Administrative Medical Staff Members shall satisfy the qualifications set forth in Section 2.2-1; provided, however, that Members of the Administrative Medical Staff are not required to maintain a Medicare/Medicaid number.
- B. Practitioners in the administrative Medical Staff category:
 - (1) Must have been board certified by the applicable national specialty board for their primary specialty/sub-specialty when such Practitioners were engaged in the active practice of medicine; or, have been granted a waiver of the board certification requirement as set forth in Section 2.2-2.
 - (2) Practitioners in the administrative Medical Staff category are encouraged but not required to maintain board certification.

11.3-2 Administrative Medical Staff Members shall:

- A. Advise and assist the Chief Medical Officer or others as appropriate with the performance of administrative responsibilities.
- B. Pay annual Medical Staff dues.

11.3-3 Administrative Medical Staff Members may:

- A. Not be granted Clinical Privileges.
- B. Teach House Staff in non-clinical areas assigned by the Section/Department Chief and provide general non-patient specific education in clinical areas provided that administrative Medical Staff Members may not impact patient care.
- C. Vote on any matters pertaining to Medical Staff business including, but not limited to, the election of Medical Staff officers; the election of at-large representatives to the Medical Executive Committee; and amendments to the Medical Staff Bylaws.

- D. Contribute to organizational, administrative, and/or business matters of the Medical Staff and Hospital.
- E. Attend educational programs of the Medical Staff and Hospital.
- F. Receive publications and communications of the Medical Staff and Hospital.
- G. Serve as a committee member or chair and vote on Medical Staff and Hospital committees of which he/she is a member; provided, however, that an administrative Medical Staff Member may not serve as an MEC at-large representative
- H. Not serve as a Medical Staff officer.
- I. Attend Medical Staff and Hospital social functions.
- J. Attend Medical Staff meetings and those Department/Section and committee meetings of which he/she is a member.
- K. Vote on matters of the Department/Section of which the Practitioner is a member.
- L. Not serve as a Department/Section Chief.

11.4 The Consulting Medical Staff

11.4-1 The consulting Medical Staff shall consist of those credentialed Practitioners who:

- A. Are of recognized professional ability and expertise to provide a service not readily available from the active Medical Staff with Privileges.
- B. Are members in good standing of the active medical staff with clinical privileges at another accredited Ohio hospital requiring performance improvement/quality assessment activities similar to those of the Hospital. The Practitioner shall hold at such other hospital the same privileges, without restriction, that he/she is requesting at Hospital. An exception to this qualification may be recommended by the Medical Executive Committee and made by the Board, in its sole discretion, for good cause provided the Practitioner is otherwise qualified by education, training, and experience to competently provide the requested care, treatment, and/or services.

11.4-2 Consulting Medical Staff Members will not be required to pay annual Medical Staff dues.

11.4-3 Consulting Medical Staff Members may:

- A. Exercise the Privileges granted; provided however, that they will not be eligible to admit patients to the Hospital.
- B. Attend Medical Staff meetings but will not be eligible to vote on Medical Staff matters; nor chair, serve, or vote on Medical Staff or Hospital committees.
- C. Attend meetings of the Department/Section of which he/she is a member but may not vote on Department/Section matters.
- D. Not hold Medical Staff office or serve as a Department/Section Chief.
- E. Attend educational programs of the Medical Staff and Hospital.
- F. Receive publications and communications of the Medical Staff and Hospital.
- G. Attend Medical Staff and Hospital social functions.

11.5 The Retired Medical Staff

11.5-1 The retired Medical Staff shall consist of current Medical Staff Members who have retired from medical practice. Members of the retired Medical Staff shall not be required to maintain a license to practice or to satisfy such other qualifications as are required of Practitioners who are granted Privileges. Current eligible Medical Staff Members may request transfer to the retired Medical Staff category in accordance with the applicable procedure set forth in the Medical Staff Credentials Policy.

11.5-2 Retired Medical Staff Members have no Medical Staff duties and are not required to pay annual Medical Staff dues or apply for reappointment.

11.5-3 Retired Medical Staff Members may:

- A. Not be granted Privileges and shall not be eligible to hold Medical Staff office or serve as a Department or Section Chief.
- B. Attend Medical Staff meetings but may not vote on Medical Staff matters.
- C. Not be assigned to a Department/Section or vote on Department/Section matters.

- D. Chair or serve on Medical Staff committees at the discretion of the President of the Medical Staff and may vote on matters for those committees to which the Practitioner is appointed.
- E. Attend educational programs of the Medical Staff and Hospital.
- F. Receive publications and communications of the Medical Staff and Hospital.
- G. Attend Medical Staff and Hospital social functions.

11.6 The Emeritus Medical Staff

11.6-1 Recognition as emeritus Medical Staff Members will be reserved for past Members of the active Medical Staff who have an outstanding record of contribution to the Hospital, an exceptional and distinctive pediatric reputation, and demonstrated commitment to the Hospital's mission and values. Members of the emeritus Medical Staff shall not be required to maintain a license to practice or to satisfy such other qualifications as are required of Practitioners who are granted Privileges. Past Members of the active Medical Staff may be nominated for the emeritus Medical Staff by any current Medical Staff Member. Appointment to the emeritus Medical Staff requires approval of the Credentials Committee and the MEC.

11.6-2 Emeritus Medical Staff Members are not required to pay annual Medical Staff dues or return reappointment forms.

11.6-3 Emeritus Medical Staff Members may:

- A. Not be granted Clinical Privileges.
- B. Attend Medical Staff meetings but may not vote on Medical Staff matters or hold Medical Staff office.
- C. Not be assigned to a Department/Section, serve as a Department/Section Chief, or vote on Department/Section matters.
- D. Chair or serve on Medical Staff committees at the discretion of the President of the Medical Staff and may vote on matters for those committees to which the Practitioner is appointed.
- E. Attend educational programs of the Medical Staff and Hospital.
- F. Receive publications and communications of the Medical Staff and Hospital.
- G. Attend Medical Staff and Hospital social functions.

11.7 The Honorary Medical Staff

11.7-1 Recognition as honorary Medical Staff Members will be reserved for past Members of the active Medical Staff who provided significant service in support of the Hospital's mission and values while a Member of the active Medical Staff. Members of the honorary Medical Staff shall not be required to maintain a license to practice or to satisfy such other qualifications as are required of Practitioners who are granted Privileges. Past Members of the active Medical Staff may be nominated for the honorary Medical Staff by any current Medical Staff Member. Appointment to the honorary Medical Staff requires approval of the Credentials Committee and the MEC.

11.7-2 Honorary Medical Staff Members are not required to pay annual Medical Staff dues or return reappointment forms.

11.7-3 Honorary Medical Staff Members may:

- A. Not be granted Clinical Privileges.
- B. Attend Medical Staff meetings but may not vote on Medical Staff matters or hold Medical Staff office.
- C. Not be assigned to a Department/Section, serve as a Department/Section Chief, or vote on Department/Section matters.
- D. Chair or serve on Medical Staff committees at the discretion of the President of the Medical Staff and may vote on matters for those committees to which the Practitioner is appointed.

11.8 The Affiliate Medical Staff

11.8-1 The Affiliate Medical Staff category shall consist of credentialed Practitioners who are not requesting Clinical Privileges but who wish to be or remain affiliated with the Hospital. Affiliate Medical Staff Members shall:

- A. Satisfy the qualifications set forth in Section 2.2-1 unless otherwise recommended by the Medical Executive Committee and approved by the Board.
- B. Be a Practitioner who seeks to follow referred patients without exercising Clinical Privileges; OR
- C. Be a Practitioner who primarily practices and has Clinical Privileges at Nationwide Children's Hospital Toledo, LLC and who is not requesting Clinical Privileges but wants to participate in various functions throughout the Hospital.

11.8-2 Affiliate Medical Staff Members are required to pay annual Medical Staff dues.

11.8-3 Affiliate Medical Staff Members may:

- A. Visit the Affiliate Medical Staff Member's referred patients, as applicable, and have view only access (no order writing, *etc.*) to the electronic health records of such patients.
- B. Attend meetings and social functions of the Medical Staff.
- C. Participate in scientific meetings and continuing medical education programs.
- D. Receive publications, notifications, and communications for the Medical Staff.
- E. Attend meetings of the Department/Section to which they are assigned.
- F. Serve as an Ex-Officio member of Medical Staff Committees.

11.8-4 An Affiliate Medical Staff Member may not:

- A. Exercise or be granted Clinical Privileges (e.g. admit, attend, diagnose, treat, consult, or actively participate in the provision of care or the management of patients in the Hospital).
- B. Vote on any Medical Staff matters including, but not limited to, the election of Medical Staff officers; at-large representatives on the Medical Executive Committee; and amendments to the Medical Staff Bylaws.
- C. Vote on Medical Staff Department/Section matters.
- D. Serve as a Medical Staff officer or Department/Section Chief.
- E. Chair a Medical Staff committee.

**ARTICLE XII
MISCELLANEOUS**

12.1 Medical History and Physical Examination Requirements

12.1-1 A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after an inpatient admission or outpatient registration, but prior to any surgery or procedure requiring anesthesia services (except in cases of emergency). When the history and physical is completed within thirty (30) days before an inpatient admission or outpatient registration, 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 an inpatient admission or outpatient registration, but prior to any outpatient or inpatient surgery or a procedure requiring anesthesia services (except in cases of emergency).

12.1-2 The history and physical, and any updated examination of the patient (to include any changes in the patient's condition), must be completed and documented by a Physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and Hospital/Medical Staff policy.

12.1-3 The history and physical, and any updates thereto, must be completed using the history and physical note type in the electronic medical record, if available, or otherwise documented in the paper medical record and made a part of the patient's medical record within twenty-four (24) hours after inpatient admission or outpatient registration of the patient but prior to surgery or a procedure requiring anesthesia services (except in cases of emergency).

12.1-4 Additional requirements regarding completion and documentation of the medical history and physical examination are set forth in applicable Hospital/Medical Staff policies.

12.2 Meeting Attendance Requirements

12.2-1 All Practitioners are encouraged to attend their specific Department/Section meetings and Medical Staff meetings for any calendar year.

12.3 Meetings

12.3-1 Requirements with respect to Medical Staff, Department/Section, and Medical Staff committee meetings shall be set forth in the Medical Staff Organizational Policy.

ARTICLE XIII
ADOPTION/AMENDMENT OF MEDICAL STAFF BYLAWS & POLICIES

13.1 Overview

- 13.1-1 The Medical Staff has the ability to adopt and amend the Medical Staff Bylaws and Policies. The Medical Staff hereby delegates to the Medical Executive Committee the responsibility to adopt and amend such Medical Staff Policies as may be necessary to implement the general principles set forth in these Bylaws and for the proper conduct of the Medical Staff.
- 13.1-2 Neither the Medical Staff or MEC, as applicable, nor the Board of Directors may unilaterally amend the Medical Staff Bylaws or Policies.
- 13.1-3 The Bylaws Committee shall periodically review the Medical Staff Bylaws and Policies as needed to assure compliance with any applicable state and federal laws, rules, or regulations, accreditation standards, and the continuing needs of the Medical Staff.
- 13.1-4 A proposal to amend the Medical Staff Bylaws or Policies may be offered by any Member of the active or administrative Medical Staff at any meeting of the Medical Staff or to a member of the Medical Executive Committee. Such proposal will be referred to the Medical Executive Committee, through the Bylaws Committee, for examination. Nothing in the foregoing is intended to prevent a voting Member of the Medical Staff from proposing amendments to the Bylaws or Policies to the Board of Directors in writing or in a manner that is otherwise determined by the Board.

13.2 Adoption or Amendment of the Medical Staff Bylaws

- 13.2-1 The Bylaws Committee will report its recommendation regarding adoption or amendment of the Medical Staff Bylaws to the Credentials Committee, if the proposed amendment relates to an issue that is governed by the Credentials Committee. The Bylaws Committee and, if applicable, the Credentials Committee will report their recommendations to the Medical Executive Committee. The Medical Executive Committee's recommendations regarding adoption or amendment of the Bylaws will be presented to the voting Medical Staff Members by the Medical Executive Committee at any Medical Staff meeting. At least 15 days advance notice of such meeting will be sent to all voting Medical Staff Members and the notice will include the wording of the Bylaws proposal to be considered. Adoption or amendment of the Medical Staff Bylaws shall require approval by two-thirds of those voting Medical Staff Members present at a Medical Staff meeting at which a quorum is present.
- 13.2-2 In the alternative, adoption or amendment of the Medical Staff Bylaws may be acted upon by ballot without a Medical Staff meeting. In such event,

ballots will be provided to Medical Staff Members eligible to vote in such manner as determined by the MEC (e.g., by email etc.) and will include a copy of the proposed Bylaws or amendments thereto. Adoption of the Bylaws or proposed amendment(s) requires the receipt of a minimum of one hundred (100) ballots and the affirmative vote of a majority of the total number of ballots received on or before the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

13.2-3 Adoption or amendment of the Medical Staff Bylaws will become effective as of the date approved by the Board of Directors.

13.2-4 The MEC shall have the power to adopt such amendments to the Medical Staff Bylaws as are, in its judgment, non-substantive in nature such as technical modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, inaccurate cross-references, or to reflect changes in committee names. The action to amend may be taken by motion acted upon in the same manner as any other motion before the MEC. After approval, such amendments shall be communicated by written notice to the Medical Staff and to the Board. Such amendments shall be effective immediately and shall be deemed approved if not objected to by the Medical Staff or the Board within thirty (30) days of adoption by the MEC.

13.3 Adoption or Amendment of Medical Staff Policies

13.3-1 The Bylaws Committee will report its recommendation regarding proposed adoption or amendment of Medical Staff Policies to the Credentials Committee if the proposed adoption or amendment relates to an issue that is governed by the Credentials Committee. The Bylaws Committee and, if applicable, the Credentials Committee will report their recommendations to the Medical Executive Committee.

- A. Recommendations for adoption or amendment of Medical Staff Policies approved by at least 80% of the Medical Executive Committee members voting and present at a meeting in which a quorum exists will be communicated to the Medical Staff and will be presented to the Board of Directors. If approved by the Board of Directors, the proposed Medical Staff Policy will be adopted or amended effective as of the date approved by the Board of Directors.
- B. Recommendations for adoption or amendment of Medical Staff Policies that do not receive at least 80% of the Medical Executive Committee vote will be presented to the Medical Staff by the Medical Executive Committee at any meeting of the Medical Staff. At least fifteen (15) days advance notice of such meeting will be

sent to all voting Medical Staff Members and the notice will include the proposed Medical Staff Policy to be considered for adoption or amendment. To be adopted or amended under the circumstances set forth in this section, a Medical Staff Policy shall require a two-thirds vote of those voting Medical Staff Members present at the meeting. Adoption or amendment of a Medical Staff Policy so accepted by the Medical Staff will be presented to the Board of Directors and, if approved, will become effective as of the date approved by the Board of Directors.

13.3-2 The Medical Staff Services Office Manager, in consultation with the Senior Vice President for Legal Services, shall have the authority to make modifications relating to cross-references, renumbering, punctuation, spelling, or other errors of grammar or expression with respect to Medical Staff Policies.

13.4 Medical Staff / Medical Executive Committee Conflict Resolution

In the event of a conflict between the Medical Staff and the Medical Executive Committee, that does not otherwise have a process for resolution under the Bylaws or Policies, a special meeting of the Medical Staff and the Medical Executive Committee shall be convened to discuss issues of concern and resolution thereof. In the event that the issue cannot be resolved to the mutual satisfaction of both parties, the matter shall be brought before the Medical Staff for vote and shall require a two-thirds vote of those Medical Staff Members eligible to vote in order to present a proposed resolution to the Board of Directors. If passed, such resolution shall be presented to the Board of Directors and shall be subject to final review and action by the Board of Directors.

13.5 Resolution of Conflict Between Documents

13.5-1 All reasonable efforts shall be made to assure that the Medical Staff Bylaws and Policies, the Hospital's code of regulations, and applicable Hospital policies are compatible with each other and compliant with applicable laws, rules, regulations, and accreditation standards.

13.5-2 If there is a conflict between the Hospital's code of regulations or policies and the Medical Staff Bylaws and/or Policies, the Hospital's code of regulations/policies shall control; provided, however, that such conflict shall then be referred to the Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved.

13.5-3 If there is a conflict between the Medical Staff Bylaws and a Medical Staff Policy, the Medical Staff Bylaws shall control; provided, however, that such conflict shall then be referred to the Medical Staff and MEC for resolution of the conflict.

**ARTICLE XIV
CONFIDENTIALITY, IMMUNITY, RELEASE OF LIABILITY**

14.1 Definitions

14.1-1 For the purposes of this Article, the following definitions shall apply:

- A. Information means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures whether in written or oral form relating to any of the subject matter specified in these Bylaws.
- B. Representative means the Board and any officer, trustee/director, or committee thereof; the Hospital and the Hospital CEO or CMO; the Medical Staff organization and any officer, Department/Department Chief, Section/Section Chief, or committee thereof; and any individual(s) (e.g., designated Hospital employees, Practitioners, APPs, etc.) authorized by any of the foregoing to carry out assigned duties on its behalf.
- C. Third Parties means both individuals and organizations providing Information to any Representative.

14.2 Authorizations and Conditions

14.2-1 By applying for, or exercising, Medical Staff appointment and/or Clinical Privileges at the Hospital, a Practitioner:

- A. Authorizes Representatives (and Third Parties, as applicable) to solicit, provide, and act upon Information bearing on his/her professional ability and qualifications.
- B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative (and Third Party, as applicable) who acts in accordance with the provisions of this Article.
- C. Acknowledges that the provisions of this Article are express conditions to his/her application for and acceptance of Medical Staff appointment/reappointment and/or grant/regrant of Clinical Privileges at the Hospital.

14.3 Confidentiality of Information

14.3-1 Information with respect to any Practitioner submitted, collected, or prepared by any Representative of this Hospital or any other health care facility or organization or medical staff for the purpose of: evaluating, monitoring, or improving the quality, appropriateness, and efficiency of

patient care; reducing morbidity and mortality; evaluating the qualifications, competence, and performance of a Practitioner or acting upon matters relating to corrective action; contributing to teaching or clinical research; determining that healthcare services are/were professionally indicated and performed in accordance with the applicable standards of care; or establishing and enforcing guidelines to help keep healthcare costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Such Information shall not be disclosed or disseminated to anyone other than a Representative or other healthcare facility or organization or medical staff engaged in an official, authorized activity for which the Information is needed; nor, be used in any way except as provided herein or except as otherwise required/permitted by law.

14.3-2 Such confidentiality shall also extend to information of like kind that may be provided by/to Third Parties. This information shall not become part of any particular patient's file or of the general Hospital records.

14.3-3 It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for corrective action.

14.4 Immunity From Liability

14.4-1 For Action Taken. No Representative (or Third Party, as applicable) shall be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

14.4-2 For Providing Information. No Representative or Third Party shall be liable to a Practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential information, to a Representative or to any other health care facility or organization or medical staff concerning a Practitioner who is or has been an applicant for Medical Staff appointment and/or Privileges, a Member of the Medical Staff, or who did or does exercise Clinical Privileges at the Hospital provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

14.5 Activities and Information Covered

14.5-1 The confidentiality and immunity provided by this Article shall apply to all Information in connection with the Hospital's activities or the activities of any other health care facility or organization or medical staff concerning, but not limited to:

A. applications for appointment/Clinical Privileges

- B. periodic reappraisals for reappointment/regrant of Privileges
- C. corrective actions
- D. hearings and appellate reviews
- E. quality assessment and performance improvement activities
- F. utilization reviews
- G. other Hospital, Medical Staff, Department/Section, or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct

14.5-2 The Information referred to in this Article may relate to a Practitioner's professional qualifications including, but not limited to, clinical ability, judgment, the ability to safely and competently exercise the Clinical Privileges requested and to sufficiently demonstrate professional competence, character, professional ethics, or any other matter that might directly or indirectly affect patient care.

14.6 Releases

14.6-1 Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the nature and intent of this Article, subject to applicable law.

14.6-2 Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

14.7 Cumulative Effect

14.7-1 Provisions in the Medical Staff Bylaws, Policies, and in application forms relating to authorizations, confidentiality of information, releases and immunity from liability shall be in addition to other protections provided by law and not in limitation thereof. In the event of conflict, the applicable law shall be controlling.