

# SECTION I BYLAWS

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## Article 1 Definitions

- 1.1 **ALLIED HEALTH PROFESSIONAL (AHP)** shall mean an individual, who is trained in some aspect of the evaluation or treatment of human illness and who is allowed, after approval through the established credentialing procedure, to perform specified services to patients at CRMC under the direction of a member of the Medical Staff or pursuant to their scope of practice as defined by their Professional Licensing Board. Allied Health Professionals are not members of the Medical Staff.
- 1.2 **APPLICANT** shall mean an individual who has been determined to be eligible to apply or reapply for Staff Appointment and/or Clinical Privileges pursuant to these Bylaws and who has so applied or reapplied.
- 1.3 **APPOINTMENT OF STAFF APPOINTMENT** means the formal designation of a Practitioner to a Medical Staff category.
- 1.4 **BOARD** means the Board of Directors of CRMC or a duly appointed sub-committee of the Board together with any such other advisory non-voting members as the Board or such sub-committee may designate.
- 1.5 **BYLAWS or MS BYLAWS** shall be this document.
- 1.6 **CHIEF EXECUTIVE OFFICER (CEO)** shall mean the Chief Executive Officer of Conway Regional Medical Center or his designee.
- 1.7 **CHIEF of STAFF (COS)** shall mean the Chief of the Medical Staff as elected by the Medical Staff or his designee.
- 1.8 **CLINICAL PRIVILEGES** shall mean the specific permission granted to a Practitioner by the Board, based on Medical Executive Committee recommendations in accordance with these MS Bylaws and MS Rules, to provide medical or other patient care services in CRMC whether in person or through the use of any medium (including electronic medium).
- 1.9 **CREDENTIALING** shall mean the process of assessing and validating the qualification of an applicant to the Medical Staff to provide patient care services in CRMC or its affiliated locations.
- 1.10 **CRMC** shall mean Conway Regional Medical Center, Inc.
- 1.11 **DENTIST** shall mean an individual who possesses a D.D.S. degree and who is licensed to practice dentistry in the State of Arkansas.
- 1.12 **DEPARTMENT** shall mean a specialized division of the Medical Staff.

- 1.13 FEDERAL HEALTHCARE PROGRAM** shall mean any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP), Tricare and the Veterans programs.
- 1.14 HE/HIM/HIS** shall mean an individual of either the male or female gender.
- 1.15 INELIGIBLE PERSON** shall mean any individual who: (1) is currently excluded, suspended, debarred or ineligible to participate in any Federal health care program, or (2) currently excluded from or holds a restricted Drug Enforcement Certification, Licensure and/or state licensure to dispense drugs or (3) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a Federal Health Care Program after a period of exclusion, suspension, debarment, or ineligibility or a limited or restricted license to practice in this or other states. Denial of any application for any of the stated reasons will result in the inability to reapply for membership and/or privileges for a period of (1) year and is excluded from Fair Hearing appeals.
- 1.16 INVASIVE PROCEDURE** shall mean “surgical entry into tissues, cavities or organs or repair of traumatic injuries” associated with: 1) an operating room, delivery room, emergency department or hospital outpatient setting; 2) cardiac catheterization and angiographic procedures; 3) vaginal or C-section deliveries or other invasive obstetric procedure during which bleeding may occur; or 4) manipulation, cutting or removal of any oral or perioral tissues, including tooth structure, during which bleeding may occur.
- 1.17 JOINT CONFERENCE** shall mean a meeting between representatives of the Board and the physician officers of the Medical Staff.
- 1.18 MEDICAL EXECUTIVE COMMITTEE (MEC)** shall mean the Executive Committee of the Medical Staff.
- 1.19 MEDICAL STAFF** shall mean the licensed practitioners and dentists who are granted Staff Appointment and Clinical Privileges.
- 1.20 MEDICAL STAFF OFFICE** shall mean that office which is staffed by employees of CRMC to serve as a resource for the entire Medical Staff and to support the committees, departments and officers of the Medical Staff in the discharge of Medical Staff responsibilities and functions.
- 1.21 PATIENT CONTACTS** means any of the following:
- 1.21.1** an inpatient admission;

- 1.21.2 an observation admission;
- 1.21.3 an inpatient consultation;
- 1.21.4 an emergency room consultation; or
- 1.21.5 an outpatient procedure requiring a physician to be present.

Notwithstanding the foregoing, admission by physicians providing locum tenens coverage for a specific physician or service line or procedures performed by Emergency Department physicians in the Emergency Department are not considered Patient Contacts for purposes of this Section 1.21.

- 1.22 **PHYSICIAN** shall mean an individual possessing an M.D. or D.O. or D.M.D. degree and who is licensed to practice medicine in the State of Arkansas.
- 1.23 **PRACTITIONER** shall mean any physician or other individual who has met the qualifications for and who has been granted Staff Appointment and Clinical Privileges at CRMC. Specifically, a Practitioner is identified as being either a physician or a dentist.
- 1.24 **PRACTITIONER RESPONSE REQUIREMENT** shall mean the ability to respond to patient care needs within thirty (30) minutes of contact by CRMC; or a more restrictive time established by a specialty or department policy, as set forth in the Medical Staff Rules and Regulations.
- 1.25 **PROCEDURES** shall mean, when used in context, those associated rules, regulations and policies established by the Medical Staff, MEC and/or Board of Directors to define the conduct of CRMC and Medical Staff functions. These associated documents are by reference incorporated in and made part of these Bylaws.
- 1.26 **QUALITY PATIENT CARE** shall mean care provided to Hospital patients at the generally recognized professional level of quality in an economically efficient manner, taking into account patient's needs, the available Hospital facilities, personnel and other resources, and utilization and quality standards in effect in the Hospital.
- 1.27 **RULES AND REGULATIONS or MS RULES** means rules, regulations, policies, procedures, protocols, standards or other requirements of the Medical Staff contained within the Medical Staff Rules and Regulations.

## **Article 2**

### **Name, Purposes and Responsibilities**

#### **2.1 NAME**

The Medical Staff of CRMC is an organizational component of CRMC consisting of Practitioners who have been granted Staff Appointment and Clinical Privileges at CRMC.

#### **2.2 PRIVACY PRACTICES**

Each Practitioner of the Medical Staff, each Allied Health Professional with Clinical Privileges, and each Practitioner with temporary privileges, shall be part of the Organized Health Care Arrangement with CRMC, which is defined in 45 C.F.R. §160.103, (which is part of what is commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows CRMC to share information with the Practitioner and the Practitioner's office for purposes of the Practitioner's payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with Practitioners, Allied Health Professionals with clinical privileges, and Practitioners with temporary privileges.

#### **2.3 PURPOSES AND RESPONSIBILITIES**

The purposes and responsibilities of the Medical Staff are:

- 2.3.1** To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with Clinical Privileges, and to provide mechanisms for accountability of the Medical Staff to the Board.
- 2.3.2** To provide patients with the quality of care that is commensurate with acceptable standards and available community resources.
- 2.3.3** To collaborate with CRMC in providing for the uniform performance of patient care processes throughout CRMC.
- 2.3.4** To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at CRMC with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource

management, and other CRMC initiatives to measure and improve performance.

- 2.3.5** To provide mechanisms for recommending to the Board through its appointed committees the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Practitioners.
- 2.3.6** To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills.
- 2.3.7** To adopt Rules and Regulations for the proper functioning of the Medical Staff, and the integration and coordination of the Medical Staff with the functions of CRMC.
- 2.3.8** To participate in identifying community health needs and establishing appropriate institutional goals.
- 2.3.9** To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, quality assessment, performance improvement, and peer review.
- 2.3.10** To pursue corrective actions with respect to members of the Medical Staff or those individuals granted Clinical Privileges, when appropriate.
- 2.3.11** To monitor and enforce Medical Staff compliance with these Bylaws, the MS Rules, and CRMC policies related to the Medical Staff.
- 2.3.12** To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.

### **Article 3 Staff Appointment**

#### **3.1 QUALIFICATIONS**

Appointment to the Medical Staff of CRMC and the grant of Clinical Privileges are extended by the Board, and not a right of any Applicant or Practitioner. -Continued exercise of any such privileges is contingent upon compliance with the MS Bylaws, the MS Rules and applicable CRMC policies. Staff Appointment and Clinical Privileges may be extended only to professionally competent Practitioners who continuously meet the qualifications set forth in the MS Bylaws and the MS Rules. All such Practitioners must also

conform to the standards of patient care imposed by law and herein, and continuously demonstrate an ability to work harmoniously with others in the orderly rendering of Quality Patient Care. Every Applicant and every Practitioner appointed to the Medical Staff and granted Clinical Privileges, and that continuously maintains the same, must demonstrate to the satisfaction of the Medical Staff and the Board the following qualifications:

### **3.1.1 Licensure and Drug Registration**

A currently valid license issued by the State of Arkansas, and currently valid registration to prescribe all medications typically used by practitioners in the same field.

### **3.1.2 Education, Training, and Experience**

Relevant training and experience. At a minimum, this includes the following:

- 3.1.2.1 Physicians:** Graduation from a medical school approved by the Arkansas State Medical Board; completion of a residency program within the Physician's specialty; and board certification or eligibility.
- 3.1.2.2 Dentists:** Graduation from a dental school approved by the Arkansas State Board of Dental Examiners.
- 3.1.2.3 Allied Health Professionals:** Compliance with any criteria specified within the MS Bylaws or the MS Rules and graduation from an educational institution approved by their professional licensing board.

### **3.1.3 Current Competence**

Current competence, as demonstrated by background, experience, demonstrated ability, availability, physical and mental health status and clinical results, which document a continued ability:

- 3.1.3.1** to provide Quality Patient Care;
- 3.1.3.2** to perform a sufficient number of procedures, manage a sufficient number of cases, and have sufficient patient care contact with CRMC to permit the Medical Staff to adequately assess the Applicant or the Practitioner's current competency;
- 3.1.3.3** to perform requested Clinical Privileges; and

**3.1.3.4** to comply with the MS Bylaws and MS Rules.

### **3.1.4 Residency and Office**

Both (1) reside and (2) maintain an office or practice closely enough to CRMC to assure that all patients under the Practitioner's care and supervision will receive continuous care consistent with the expected needs, especially in cases of emergency. The MEC may, but is not required to, further define the foregoing requirement with respect to Staff Categories, particular classes of Practitioners and/or particular Clinical Privileges in the MS Rules.

### **3.1.5 Effect of Affiliations**

No Practitioner or Applicant is automatically entitled to initial or renewed Staff Appointment or particular Clinical Privileges for any reason, including, but not limited to the fact that he:

- 3.1.5.1** is licensed to practice in this or any other state;
- 3.1.5.2** is a member of any professional organization;
- 3.1.5.3** is certified by any clinical board;
- 3.1.5.4** is a member of the faculty of a medical school;
- 3.1.5.5** has had, or presently has, Staff Appointment or Clinical Privileges at CRMC or another health care facility or in another practice setting;
- 3.1.5.6** is, or has been, employed by CRMC or another hospital;
- 3.1.5.7** is, or has been, an independent contractor of CRMC or another hospital; or
- 3.1.5.8** is, or has been, a panel provider for any insurance company, health maintenance organization, preferred provider organization, independent practice association, or physician hospital organization.

### **3.1.6 Conflict of Interest**

Freedom from any actual or potential conflict of interest with CRMC or its patients. Accordingly, each Applicant and Practitioner must disclose to CRMC any business relationships or ownership interests they have with any suppliers, subcontractors, professional firms, or other entities that do business with or could do business with CRMC or its affiliates, or possibly compete with CRMC. If the

Credentials Committee determines that any such relationship or interest creates an actual, potential or perceived conflict of interest that adversely affects the best interests of CRMC or its patients, such Applicant or Practitioner shall take such steps as the Credentials Committee determines are necessary to resolve the issue. Failure to disclose such relationship or interest or to take such steps to resolve the issue as determined by the Credentials Committee may constitute grounds for denial of an application or reapplication or for corrective action.

### **3.1.7 Attitude**

A willingness and capability, based on current attitude and evidence of past performance:

- 3.1.7.1** to work with and relate to other Practitioners, students, members of other health disciplines, CRMC administration and employees, visitors and the community in general, in the cooperative, professional manner that is essential for maintaining a hospital environment appropriate to Quality Patient Care;
- 3.1.7.2** to participate equitably in the discharge of Staff responsibilities;
- 3.1.7.3** to adhere to all applicable ethical standards and principles;
- 3.1.7.4** to avoid conduct that suggests a lack of professional fitness; and
- 3.1.7.5** to actively participate in the charitable mission of CRMC to provide quality healthcare to all persons regardless of race, creed, color, sex, disability, religion, or ability to pay for care, and to demonstrate a commitment to the furtherance and betterment of the hospital environment of CRMC and the community served by CRMC.

### **3.1.8 Disability**

Freedom from, or adequate control of, any significant physical, mental or behavioral impairment and any difficulty in communicating verbally or in writing in the English language that interferes with, or presents a substantial possibility of interfering with, the requirements of the MS Bylaws or the MS Rules, such that Quality Patient Care, the exercise of Clinical Privileges, the assumption of required responsibilities, or cooperative working relationships is or is likely to be adversely affected.

### **3.1.9 Professional Liability Insurance**

Professional liability coverage with a licensed and approved carrier with a minimum limit of one million dollars (\$1,000,000) per claim or medical incident and three million dollars (\$3,000,000) in the aggregate, or such greater limited as the Board (in consultation with MEC) may establish commensurate with the Applicant or Practitioner's specialty, Staff category or particular Clinical Privileges. Such professional liability insurance shall include a policy or policies with prior acts coverage and/or extended reporting endorsements ("tail coverage") with a retroactive date that continuously covers all claims arising out of acts which occur from the date the Practitioner is originally granted Staff Appointment and Clinical Privileges.

Upon any change of professional liability insurance carriers by the Practitioner for any reason, or receipt of notice that his professional liability coverage will be terminated, reduced or limited for any reason, the Practitioner shall:

- 3.1.9.1** Notify the Chief Executive Officer at least ten (10) business days prior to the expiration date of current coverage; and
- 3.1.9.2** Obtain the requisite amount of minimum coverage which contains a retroactive date sufficient to cover any claims ensuring out of acts which occurred from the date the Practitioner was originally appointed to the Medical Staff or granted Clinical Privileges through and including the expiration date.

### **3.1.10 Qualifications Not Exclusive**

The foregoing general qualifications shall not be deemed exclusive of other qualifications and conditions deemed by CRMC or the Credentials Committee to be relevant in considering an Applicant's or Practitioner's qualifications.

## **3.2 BASIC RESPONSIBILITIES**

Each Practitioner, as a condition of exercising Clinical Privileges under the MS Bylaws and the MS Rules, shall:

- 3.2.1** provide patients with Quality Patient Care;
- 3.2.2** abide by and be subject to the MS Bylaws, MS Rules, CRMC Bylaws and CRMC policies related to medical care;
- 3.2.3** discharge such Staff, committee, and CRMC functions for which he is responsible by Staff category assignment, appointment, election or otherwise, including, but not limited to participation in the unassigned call system and otherwise providing back-up or consultation to other Practitioners to the extent required by CRMC or federal and state law;

- 3.2.4** prepare and complete in a timely, accurate, complete and legible manner the medical and other required records for all patients he admits or in any way provides care to in CRMC;
- 3.2.5** abide by generally recognized standards of professional ethics, including, but not limited to: refraining from fee splitting or other inducements relating to patient referral; providing continuous care for his patients; refraining from delegating the responsibility for diagnosis or care of hospitalized patients to any Practitioner who is not qualified to undertake this responsibility and who is not adequately supervised; seeking consultation wherever necessary; and refraining from providing "ghost" surgical or medical services;
- 3.2.6** upon request of CRMC or the Medical Staff, provide appropriate and necessary emergency and non-emergency medical treatment within the scope of the Practitioner's Clinical Privileges to any patient seeking such treatment, regardless of the patient's ability to pay;
- 3.2.7** satisfy the continuing education requirements established by the MEC;
- 3.2.8** work cooperatively with Medical Staff officers, committees, and CRMC administration to meet and practice within the guidelines and review plan established by CRMC or the Quality Improvement Organization (QIO) utilized by CRMC, to minimize or eliminate disallowed admissions, to eliminate technical diagnosis entry and coding errors, and to order or utilize supporting and ancillary services only when necessary and to shorten lengths of stay at CRMC where medically appropriate;
- 3.2.9** cooperate openly and fully in any required health assessments;
- 3.2.10** cooperate in any review of his (or another Applicant's or Practitioner's) credentials, qualifications, professional activities, or compliance with MS Bylaws and MS Rules and CRMC policies related to medical care; and refrain from directly or indirectly interfering, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities, or otherwise;
- 3.2.11** notify the Chief Executive Officer within ten (10) business days following the receipt by the Practitioner of any notice of:
- 3.2.11.1** the initiation of any formal process which could result in the revocation or suspension of the Practitioner's professional license, or the imposition of terms of probation or limitation of the Practitioner's practice by any state licensing agency;

- 3.2.11.2** the recommendation at another hospital or health care facility where such Practitioner holds medical staff membership or privileges of corrective or disciplinary action with respect to such Practitioner. (The term “corrective” or “disciplinary” action as used in the preceding sentence includes the summary suspension of all or part of the Practitioner’s clinical privileges or a recommendation (whether proposed or final)) of any medical staff or board committee of:
- (a) probation, consultation or supervision;
  - (b) reduction, suspension, revocation or limitation of clinical privileges;
  - (c) reduction, suspension, revocation or limitation of any medical staff prerogatives directly related to patient care;
  - (d) suspension or revocation of medical staff membership; or
  - (e) denial of reappointment or reapplication for any clinical privileges;
- 3.2.11.3** the initiation by the QIO of any formal process concerning the quality of the Practitioner’s care;
- 3.2.11.4** the initiation of any formal process which could result in the revocation or suspension of the Practitioner’s DEA number, or the imposition of terms of probation or limitation of the Practitioner’s rights to prescribe any medication;
- 3.2.11.5** the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or any state;
- 3.2.11.6** the filing of a lawsuit against the Practitioner related to the Practitioner’s professional conduct;
- 3.2.11.7** the filing of felony charges against the Practitioner; or
- 3.2.11.8** any exclusion or preclusion from Medicare, Medicaid, or other governmental health program;
- 3.2.11.9** provide CRMC with complete information as to the reasons for the proceedings described in Section 3.2.11 above, and shall make available to CRMC all information concerning any

such proceedings, including the details relating to any final disposition of such proceedings.

### **3.2.3 History and Physical**

Each Practitioner who admits or in any way provides medical care to a patient at CRMC must complete and document a medical history and physical examination for each patient admitted no more than thirty (30) days before or twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia. If the medical history and physical examination are completed prior to admission, an updated medical history and physical, including any changes in the patient's condition, must be completed, and documented within twenty-four (24) hours of admission, but prior to surgery or a procedure requiring anesthesia. In the event the patient is presenting for an outpatient procedure, the Practitioner shall complete a history and physical on the date of the procedure and prior to commencing of the surgery or procedure requiring anesthesia or update a history and physical completed within the thirty (30) days prior to the outpatient procedure. Such medical history and physical shall be completed and documented by a Practitioner, AHP, or by other qualified licensed individuals in accordance with the MS Rules. The minimum required content of a history and physical examination is set forth in the MS Rules.

## **3.3 ALLIED HEALTH PROFESSIONALS**

AHPs shall be assigned to a Department and provisions shall be made for certain types of non-physician and non-dental professional to be appointed and granted authority to perform specified skills under the supervision of a member of the Medical Staff ("Clinical Activities"), as outlined in the MS Rules. AHPs are not members of the Medical Staff and are not afforded any rights under the MS Bylaws or MS Rules.

## **3.4 NONDISCRIMINATION**

CRMC and the Medical Staff will not discriminate in granting Medical Staff Appointment and/or Clinical Privileges on basis of age, gender, race, creed or national origin.

## **3.5 MEDICAL STAFF CATEGORIES**

Each member of the Medical Staff shall be assigned to a category in accordance with the criteria defined in these Bylaws and the MS Rules, and shall be subject to the responsibilities and prerogatives of that category.

The Medical Staff consists of Active, Active Affiliate, Consulting, Outpatient, Associate/Call, Dental, Telemedicine, and House categories.

### 3.5.1 Active Staff

To qualify for Active Staff Appointment, a Practitioner must:

- 3.5.1.1 be a Physician or dentist;
- 3.5.1.2 meet the basic qualifications set forth in Section 3.1;
- 3.5.1.3 meet such other qualifications as are established in the MS Rules or deemed by CRMC or the Medical Staff to be relevant in considering an Applicant's or Practitioner's qualifications; and
- 3.5.1.4 regularly practice at CRMC, or be otherwise regularly involved in the care of patients in CRMC. "Regularly" is defined as the Practitioner has more than two hundred (200) Patient Contacts per Staff Year.

### 3.5.2 Active Staff Affiliate

To qualify for Active Staff Affiliate Appointment, a Practitioner must:

- 3.5.2.1 Be a Physician or dentist;
- 3.5.2.2 Meet the basic qualifications set forth in Section 3.1;
- 3.5.2.3 Does not admit or actively participate in the care of patients at the Hospital because such Practitioner's professional practice is solely ambulatory in nature (e.g., internists, family practitioners and pediatricians who have a primary office practice);
- 3.5.2.4 agrees to reassume the care and treatment of such patients following discharge from CRMC; and
- 3.5.2.5 meet such other qualifications as are established in the MS Rules or deemed by CRMC or the Medical Staff to be relevant in considering an Applicant's or Practitioner's qualifications; and

### 3.5.3 Active Staff Prerogatives

The prerogatives of a Practitioner with Active Staff and Active Staff Affiliate Appointment are to:

- 3.5.3.1 exercise such Clinical Privileges as are granted to him;

**3.5.3.2** attend general and special meetings of the Medical Staff and committees of which he is a member and vote on any matters presented there unless otherwise provided; and

**3.5.3.3** hold office in the Medical Staff and any committee of which he is a member, unless otherwise provided.

**3.5.4 Active Staff Responsibilities**

Each Practitioner with Active Staff and Active Staff Affiliate Appointment shall:

**3.5.4.1** retain responsibility within his area of professional competence for the continuous care and supervision of each patient in CRMC for whom he is providing services, or arrange a suitable alternative for such care and supervision;

**3.5.4.2** contribute to the organizational and administrative affairs of the Medical Staff, including service on CRMC and Medical Staff committees, faithfully performing the duties of any office or position to which elected or appointed;

**3.5.4.3** be subject to and participate actively in utilization review and other quality evaluation and monitoring activities required of the Medical Staff;

**3.5.4.4** unless otherwise excused by MS Rules, MEC action, or these Bylaws, discharge the recognized functions of Active Staff Appointment by engaging in the Medical Staff's teaching and continuing education programs, providing coverage for unassigned patients in the emergency department as required; providing on-call coverage as required; attending service or charity patients as required, providing consultation to other Practitioners consistent with his delineated Clinical Privileges, and fulfilling such other Staff functions as may reasonably be required of Practitioners; and

**3.5.4.5** pay any dues and assessments regularly and promptly.

**3.5.5 Consulting Staff**

To qualify for Consulting Staff Appointment, a Practitioner must:

**3.5.5.1** be a Physician or dentist; and

- 3.5.5.2** not wish for or meet the criteria to have active staff membership, but desire to order certain routine outpatient tests and treatment therapies at CRMC.
- 3.5.5.3** A Practitioner may request invasive Clinical Privileges as a Consulting Staff physician under the following generally accepted guidelines, not to be unreasonably withheld:
- 3.5.5.3.1** Review and recommendation by the majority of Active Staff members in the Specialty;
  - 3.5.5.3.2** Review and approval of the MEC should the specialty or procedure in question be new to CRMC or the Specialty and requesting Practitioner be unable to fully resolve credentialing requirements;
  - 3.5.5.3.3** Call and coverage will be addressed to the satisfaction of the MEC and Specialty in question. Call and coverage expectations may vary by Specialty, activity, intensity, and other relevant factors that pertain to patient care.

The granting of invasive Clinical Privileges to a Consulting Staff Practitioner is not and should never be a substitute for Active Staff status. If, pursuant to review by the MEC, the Consulting Staff Practitioner meets or exceeds an activity level equivalent to that of an Active Staff Physician, with the same or similar invasive Clinical Privileges, then the Consulting Practitioner in question will automatically become a part of the Active Staff, and will be responsible for all the duties and obligations attendant such position. Upon such review and consideration, the Specialty in question, in conjunction with the MEC, will determine if call and coverage arrangements need to be amended to accommodate the best interests of patient care. This review will occur at reappointment of the Consulting Staff Practitioner unless raised before the Credentials Committee during the current Appointment period.

### **GUIDELINES**

- i. Retain responsibility for continuous care and supervision of each patient in the hospital for whom he/she is providing service OR arrange

- for alternative care.
- ii. Must have call coverage arrangements within CRMC. A denial of a requested Invasive Clinical Privilege should never be solely based on competitive influences or bias.
- iii. Existing specialty may recommend alternative call requirements.
- iv. Exception for Consulting Staff Practitioners should primarily be granted based on Services Lines that do not currently exist or those Services Lines that are underserved.

### **3.5.6 Consulting Staff Prerogatives**

The prerogatives of a Practitioner with Consulting Staff Appointment are to:

- 3.5.6.1** exercise such Clinical Privileges as are granted to him/her;
- 3.5.6.2** attend general and special meetings of the Medical Staff and committees of which he/she is a member;
- 3.5.6.3** not be eligible to vote on any matters presented there unless otherwise provided; and
- 3.5.6.4** not serve as an officer of the Medical Staff or Department or committee chair.

### **3.5.7 Consulting Staff Responsibilities**

Each Practitioner with Consulting Staff Appointment shall:

- 3.5.7.1** retain responsibility within his/her area of professional competence for the consulting and supervision of each patient in CRMC for whom he is providing services, or arrange a suitable alternative for such care and supervision;
- 3.5.7.2** be subject to and participate actively in utilization review and other quality evaluation and monitoring activities required of the Medical Staff;
- 3.5.7.3** unless otherwise excused by MS Rules, MEC action, or these Bylaws, discharge the recognized functions of Consulting Staff Appointment by engaging in the Medical Staff's teaching and continuing education programs; attending service or charity patients as required, providing consultation to other Practitioners consistent with his delineated Clinical Privileges,

and fulfilling such other Staff functions as may reasonably be required of Practitioners; and

- 3.5.7.4** pay any dues and assessments regularly and promptly.

**3.5.8 Associate/Call Staff**

To qualify for Associate/Call Staff Appointment, a Practitioner must:

- 3.5.8.1** be a Physician or dentist meeting the basic qualifications as set forth in Section 3.1 except as outlined below;
- 3.5.8.2** not fully meet the Residence and Office requirement as set forth at Section 3.1.4;
- 3.5.8.3** not regularly practice at CRMC as defined at Section 3.5.1.4; and,
- 3.5.8.4** is on the active staff at another hospital or a credentialed member at another health system with the same clinical privileges as requested and requires privileges at CRMC for the purpose of providing call and/or specialty coverage for an Active Member of the Medical Staff.

**3.5.9 Associate/Call Staff Prerogatives**

The prerogatives of a Practitioner with Associate/Call Staff Appointment are to:

- 3.5.9.1** exercise such Clinical Privileges as are granted to him;
- 3.5.9.2** attend general and special meetings of the Medical Staff and department of which he is an appointee and any staff or CRMC education program;
- 3.5.9.3** not be eligible to vote on departmental or Medical Staff matters; and
- 3.5.9.4** not serve as a Medical Staff officer or Department or committee chair.

**3.5.10 Associate/Call Staff Responsibilities**

Each Practitioner with Associate/Call Staff Appointment shall:

- 3.5.10.1 continuously satisfy the qualifications for Medical Staff Appointment set forth above, and apply for appointment and for reappointment;
- 3.5.10.2 retain responsibility within his area of professional competence for the continuous care and supervision of each patient in CRMC for whom he is providing services until such care is transferred to the Active Member of the Medical Staff for which he is providing coverage;
- 3.5.10.3 be subject to and participate actively in utilization review and other quality evaluation and monitoring activities required of the Medical Staff;
- 3.5.10.4 provide the call coverage as set out in the Active Appointee's call rotation including making a personal appearance to assess patients in the Emergency Department when deemed appropriate by the Emergency Department physician; and
- 3.5.10.5 pay any dues and assessments regularly and promptly.

Failure to carry out the responsibilities or meet the qualifications as enumerated for Active, Active Affiliate, Consulting, or Associate/Call categories shall be grounds for corrective action, including, but not limited to, termination of Appointment to the Medical Staff and Clinical Privileges.

- 3.5.11 **Outpatient Staff**-- those Practitioners who do not wish to have admitting or other clinical privileges at CRMC other than the ordering of certain routine outpatient tests or treatments.
- 3.5.12 **Dental Staff**--dentists who maintain an active practice in the community and wish to have an affiliation with CRMC for consultation purposes.
- 3.5.13 **Telemedicine Staff**--the telemedicine staff shall consist of Practitioners providing care, treatment and services of patients only via an electronic communication link at a distant-site as defined by the MS Rules. These Practitioners are subject to the credentialing and privileges process of CRMC.
- 3.5.14 The qualifications, duties and responsibilities of each staff category shall be further delineated in the MS Rules.

### 3.5.15 Special Conditions with Regard to Exclusive Contracts

In the event the Hospital contracts to provide specific services with an individual or group of Physicians (“Contractor”) on an exclusive basis (“Exclusive Contract”), and unless such contract so specifies to the contrary, the following provisions shall apply:

- 3.5.15.1** Each Practitioner providing services under the Exclusive Contract must also be affiliated with (i.e., be a member of, employee of, or independent contractor of) the Contractor.
- 3.5.15.2** Each such Practitioner’s Staff Appointment and Clinical Privileges automatically terminates (without the rights provided in Articles Five and Six hereof) in the event that the Practitioner ceases to be affiliated with the Contractor or if the Exclusive Contract with the Hospital is terminated.
- 3.5.15.3** In the event the Hospital contracts for an entire clinical area, the contract for such services shall designate the Chief of such area.

### **3.6 HOUSE STAFF**

“House Staff” includes a “Physician-in-Training” within the CRMC Residency Program. All Physicians-in-Training within the Residency Program are automatically appointed as House Staff of CRMC. Such appointment shall be co-terminus with the Residency Program appointment held by such Physician-in-Training.

#### **3.6.1 Medical Staff Membership**

Members of the House Staff are not eligible for membership on the Medical Staff and must be under the supervision of the Program Director and an assigned attending physician. A Department Chair may request privileges for House Staff to perform clinical work in a medical discipline for which the House Staff member has had previous training if the privilege requested is unrelated to the area of their current training. Such applicants must meet all requirements, qualifications, and responsibilities of the Medical Staff, and are subject to the policies as may be established by the Program Director and the Chief of Staff. House Staff are eligible to serve on committees and to function in the clinical areas of CRMC within the limitations of their appointment. The House Staff are not eligible to admit patients. House Staff may attend Medical Staff, department, and committee meetings when invited to do so, but are not voting members of the Medical Staff.

#### **3.6.2 No Independent Privilege**

Members of the House Staff do not have independent privileges to admit or treat patients at CRMC. The House Staff are employees of CRMC and their scope of practice is defined by the Graduate Medical Education Committee (“GMEC”). Specific policies and procedures governing the oversight of House Staff within CRMC are set forth in the Resident Policies and Procedures manual. House Staff will act under the supervisions and credentials of a Medical Staff member in accordance with all CRMC policies. House Staff are not subject to fees or dues. An official list of current Housed Staff Members will be kept in the Residency Program office and the Medical Staff Office.

### **3.6.3 No Fair Hearing Rights**

The various provisions of the Medical Staff Bylaws shall apply to members of the House Staff only as specifically provided. Provisions relating to appeals, fair hearing and appellate review shall not apply to the House Staff including, but not limited to those rights set forth in Article Five. Any issues related to a member of the House Staff will be directed to the Program Director and the GMEC for further action as set forth in the Residency Policies and Procedures manual.

## **3.7 APPOINTMENT AND REAPPOINTMENT**

### **3.7.1 General Procedure**

The Medical Staff, through its Committees and Officers, shall investigate and consider each application or reapplication for Appointment or Reappointment and each request for modification of Staff Appointment or Clinical Privileges and shall adopt and transmit recommendations to the Board. The Board is responsible for Staff Appointment and Reappointment and the granting of Clinical Privileges.

### **3.7.2 Preliminary Eligibility Criteria**

Only when a person can first establish that he meets each of the following preliminary eligibility criteria is he eligible to apply or reapply for Staff Appointment and/or Clinical Privileges:

- 3.7.2.1** that he meets the Licensure and Education, Training and Certification requirements of MS Bylaws 3.1.1 and 3.1.2;
- 3.7.2.2** that the Clinical Privileges to be sought are not subject to an exclusive contract with a Physician or group of Physicians not including such person;

- 3.7.2.3 that the Clinical Privileges to be sought are not inconsistent with CRMC's written medical staff development plan;
- 3.7.2.4 that he is not ineligible to apply or reapply for Staff Appointment and/or Clinical Privileges pursuant to the MS Bylaws or MS Rules;
- 3.7.2.5 that he has no other application or reapplication for Staff Appointment and/or Clinical Privileges pending or subject to further hearing, appellate review or other proceedings before the Medical Staff or Board; and
- 3.7.2.6 that he has no judicial proceeding pending concerning another application or reapplication for Staff Appointment and/or Clinical Privileges at CRMC.
- 3.7.2.7 that he has actively practiced medicine (including residency) at least twelve (12) months out of the last twenty-four (24) months; and
- 3.7.2.8 that he is not listed on the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs or otherwise listed by a governmental agency as excluded, disbarred, suspended, or otherwise ineligible to participate in federal or state healthcare programs, including but not limited to the Medicare and Medicaid programs.

### **3.7.3 Application and Reapplication Form**

Each application and reapplication shall be in writing, submitted on a form prescribed by CRMC, and signed by the Applicant. When an Applicant or Practitioner requests an application form he shall be given access to a copy of these Bylaws and the MS Rules.

### **3.7.4 Effect of Application or Reapplication**

By applying or reapplying for Appointment or Clinical Privileges, each Applicant:

- 3.7.4.1 Consents to the inspection of records and documents pertinent to his licensure, specific training, experience, current competence, ability to perform the privileges requested, and health status;
- 3.7.4.2 Signifies his willingness to appear for interviews in regard to his application, if requested;

- 3.7.4.3** Agrees to be bound by the provisions of these Bylaws and the MS Rules regardless of whether his application is approved including, without limitation, the provisions of Article Eleven of the MS Bylaws providing for confidentiality, immunity, release from liability, authorizations, special covenants and other matters;
- 3.7.4.4** Represents and warrants that all information provided by him is true, correct and complete in all material respects, and agrees to notify CRMC of any change in any of the information furnished CRMC; and
- 3.7.4.5** Pledges to provide continuous care for his patients.

### **3.7.5 Applicant's Burden**

An Applicant or Practitioner applying or reapplying for Staff Appointment or Clinical Privileges shall have the burden of producing adequate information for a proper evaluation of his current licensure, relevant training or experience, current competence, professional judgment, demonstrated ability to perform the Clinical Privileges requested, professional ethics, physical and mental health status, emotional stability, ability to work harmoniously with others, and other qualifications and of resolving any doubts about these or other basic qualifications specified in these Bylaws and of satisfying any reasonable requests for information or clarification (including health examinations) made by appropriate Medical Staff or Board authorities. Failure to adequately complete the required form, the withholding of or other failure to produce requested information, the providing of false, incomplete or misleading information, or other failure of the Applicant or Practitioner to meet his burden, shall, in and of itself, constitute a basis for denial of the application or reapplication or revocation of Staff Appointment and Clinical Privileges.

### **3.7.6 Denial for Hospital's Inability to Accommodate**

In addition to other bases specified herein, Staff Appointment and/or particular Clinical Privileges may be denied on the basis that the Hospital is presently unable to provide adequate facilities, equipment, number or types of qualified support personnel, support services or patient load for the affected Applicant or Practitioner and his patients. Such a recommendation of denial shall not be considered adverse in nature.

### **3.7.7 Application for Initial Appointment**

- 3.7.7.1** A statement that the Applicant has received and read the MS Bylaws and MS Rules and that he agrees to be bound by the terms thereof, along with CRMC policies related to medical care, if he is granted Staff Appointment and/or

Clinical Privileges, and to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not the application is granted;

- 3.7.7.2** Detailed information concerning the Applicant's qualifications, including, without being limited to, information and satisfaction of the basic qualifications specified in Article Three of the MS Bylaws;
- 3.7.7.3** Postgraduate training, including the name of each institution, degrees granted, program completed, dates attended, and names of practitioners responsible for the Applicant's performance;
- 3.7.7.4** All currently valid medical, dental and other professional licensures or certifications, and DEA registration, with the date and number of each;
- 3.7.7.5** A current picture hospital ID card or a valid picture ID issued by a state or federal agency;
- 3.7.7.6** Specialty or subspecialty board certification, recertification and eligibility;
- 3.7.7.7** Health impairments (including any alcohol or drug abuse problems), if any, affecting the Applicant's ability in terms of skill, attitude or judgment to fully perform professional and Medical Staff duties; hospitalizations or other institutionalizations for significant health problems during the past five (5) years; any continuing health problems requiring current therapy; a current TB test or completion of a questionnaire regarding status if previously positive.
- 3.7.7.8** Professional liability insurance coverage, and information on professional liability claims and experience (suits and settlements made, concluded and pending) during the past ten (10) years, including the names of present and past insurance carriers and consent to the release of information by the Applicant's present and past professional liability carriers;
- 3.7.7.9** If the application is for Appointment as an Allied Health Professional and the Applicant is an employee of a Physician Practitioner, the application shall include an agreement signed by such Physician Practitioner employer indemnifying

and holding the Hospital harmless against all claims and losses arising out of the acts or omissions of the Applicant;

- 3.7.7.10** Specific requests stating the Staff category and Clinical Privileges for which the Applicant wishes to be considered;
- 3.7.7.11** Letters of references from at least three persons who are not related to him who have worked with the Applicant and directly observed his professional performance in the recent past and who can provide specific, reliable, substantive, written information based on significant personal experience as to the Applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism and other qualifications for eligibility under the MS Bylaws and MS Rules;
- 3.7.7.12** Information as to whether any of the following have ever been (whether voluntarily or involuntarily) denied, revoked, suspended, limited, reduced, not renewed, relinquished, terminated, lost, made subject to probation, preceptorship, or monitoring requirements or have been the subject of a letter of warning, reprimand or otherwise:
  - 3.7.7.12.1** staff membership status or clinical privileges at any other hospital, clinic, or healthcare institution;
  - 3.7.7.12.2** status or participation in any HMO, PPO, PHO, or insurance company provider panel or managed care entity program;
  - 3.7.7.12.3** status in or participation in the Medicare or Medicaid programs or any other federal or state health insurance program;
  - 3.7.7.12.4** membership/fellowship in local, state or national professional organizations;
  - 3.7.7.12.5** specialty board certification/eligibility;
  - 3.7.7.12.6** license to practice any profession in any jurisdiction;
  - 3.7.7.12.7** DEA or other controlled substances registration; or

- 3.7.7.12.8** faculty membership at any medical or other professional school.

Full details regarding any of the above shall be included as part of the application.

- 3.7.7.13** Information as to whether any formal complaints, requests for corrective action, investigations, hearings, appeals, or other processes concerning any of the following are threatened, pending or in process;

- 3.7.7.13.1** staff membership status or clinical privileges at any other hospital, clinic, or healthcare institution;

- 3.7.7.13.2** status or participation in any HMO, PPO, PHO, or insurance company provider panel or managed care entity program;

- 3.7.7.13.3** status in or participation in the Medicare or Medicaid programs or any other federal or state health insurance program;

- 3.7.7.13.4** membership/fellowship in local, state or national professional organizations;

- 3.7.7.13.5** specialty board certification/eligibility;

- 3.7.7.13.6** license to practice any profession in any jurisdiction;

- 3.7.7.13.7** DEA or other controlled substances registration; or

- 3.7.7.13.8** faculty membership at any medical or other professional school.

Full details regarding any of the above shall be included as part of the application.

- 3.7.7.14** Any additional information required of a Practitioner under Section 3.2.12;

- 3.7.7.15** Location of offices, names and addresses of other practitioners with whom the Applicant is or was associated and inclusive dates of such association; names and locations of any other hospital, clinic, or health care institution or

organization where the Applicant provides or has provided clinical services with the inclusive dates of such affiliation;

- 3.7.7.16** Any current felony criminal charges pending against the Applicant and any past charges including their resolution;
- 3.7.7.17** A statement whereby the Applicant agrees that, should an adverse ruling be made with respect to this application for Staff Appointment and/or Clinical Privileges, he will exhaust the administrative remedies afforded by the MS Bylaws or MS Rules before resorting to legal action;
- 3.7.7.18** A statement whereby the Applicant specifically agrees to the authorization, confidentiality, immunity and release provisions of the MS Bylaws, and the special covenants contained in Article Eleven;
- 3.7.7.19** A statement whereby the Applicant agrees, if granted Clinical Privileges, to provide continuous quality care for patients;
- 3.7.7.20** A statement whereby the Applicant agrees, if granted Clinical Privileges, as required by Medical Staff or Department Rules or upon specific request of a Medical Staff Officer, to provide: (1) appropriate and necessary emergency medical treatment; and (2) appropriate and necessary non-emergent treatment required by law or governmental regulations, within the scope of the Practitioner's Clinical Privileges to any CRMC patient seeking such treatment, regardless of the patient's ability to pay;
- 3.7.7.21** A statement whereby the Applicant affirms that he is:
  - 3.7.7.21.1** not, to the best of Applicant's knowledge, currently subject to intensified records review by, or on behalf of, any payor (including Medicare or Medicaid), medical staff, or healthcare facility;
  - 3.7.7.21.2** not, to the best of Applicant's knowledge, current subject to prior authorization or prepayment review by, or on behalf of, the Medicare or Medicaid programs as a result of previous billing irregularities;

**3.7.7.21.3** not a party to any closed-end provider agreement with the Medicare or Medicaid programs;

**3.7.7.22** Full disclosure of any agreement, contract, or other arrangement entitling Applicant to receive, directly or indirectly, payments or other remuneration from any pharmaceutical, medical device or supply manufacturer, wholesaler, reseller, distributor, or retailer; and

**3.7.7.23** The signature of the Applicant.

### **3.7.8 Processing the Application**

The Applicant shall deliver a completed application form to the Medical Staff Office, who shall, in timely fashion, seek to collect or verify the identification of the Applicant, references, licensure, and other qualification evidence submitted. The Medical Staff Office shall promptly notify the Applicant of any problems in obtaining the information required and it shall then be the Applicant's obligation to obtain the required information. When such collection and verification are accomplished, the Medical Staff Office shall deem the application and supporting documentation to be complete and shall then notify the Chief of Staff and transmit the application and supporting documentation to the Credentials Committee.

### **3.7.9 Term of Appointment**

All initial Staff Appointments and grants of Clinical Privileges, and all modifications thereof, shall be for a period of not more than three (3) years. Reappointments to any category of the Medical Staff and the renewal of Clinical Privileges shall be for a period not more than three (3) years. The MEC, in its discretion, may establish MS Rules that set a more frequent reappraisal period for the exercise of particular Clinical Privileges in general. The Credentials Committee, in its discretion, may set a more frequent reappraisal period for individual Practitioners.

### **3.7.10 Clinical Privileges**

A Practitioner shall be entitled to exercise only those Clinical Privileges specifically granted by the Board. Such Clinical Privileges must be within the scope of the license, certificate or other legal credentials authorizing him to practice in this State and consistent with any restrictions thereon, within the scope of the Practitioner's current competence and shall be subject to the MS Rules. Regardless of the Clinical Privileges granted, each Practitioner must obtain consultation when the clinical needs of the patient exceed the Clinical Privileges of the Practitioner or when necessary for the safety of his patients or when required by the MS Rules.

### **3.7.11 MEC Obligations**

The Medical Executive Committee shall recommend and adopt specific preliminary eligibility criteria, application and reapplication forms and the standards, criteria, and procedures for application, reapplication and modification of Staff Appointment and Clinical Privileges.

## **3.8 TEMPORARY STAFF APPOINTMENT AND CLINICAL PRIVILEGES**

**3.8.1** Upon written request for specific temporary Staff Appointment and Clinical Privileges on the proper form at least five (5) business days (or less with respect to an important patient care need, if necessary) prior to the proposed date for the Clinical Privileges and with the written concurrence of the Chief of Staff, Chair of the Credentials Committee and the Department Chair, the CEO or his designee may grant temporary Clinical privileges in the following instances:

- a. The justification for the request of temporary clinical privileges should be limited to fulfilling an important patient care need. Temporary privileges can be granted on a case-by-case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Situations that may require temporary privileges include but are not necessarily limited to situations where (i) a current Practitioner of the Medical Staff becomes ill or takes a leave of absence and a physician would need to cover his/her practice until he/she returns, and (ii) a specific physician has the necessary skills to provide care to a patient that a Practitioner currently privileged does not possess.
- b. If the requestor is not an appointee to the Medical Staff: Temporary privileges may be granted provided, that, there is documentation and verification of current unrestricted Arkansas Professional License, relevant training, current competence to perform the privileges requested, Malpractice Insurance Coverage of specified amounts, a valid unrestricted DEA Certificate (where applicable), and the applicant is Board Certified or Board Qualified. Special requirements of consultation and reporting may be imposed by the Department Chair for the supervision of a practitioner granted temporary Clinical Privileges. Before temporary Clinical Privileges are granted, the Practitioner must acknowledge in writing that he has received, or has been given access to, and read the MS Bylaws and MS Rules and that he agrees to be bound by the terms thereof in all matters relating to his temporary Clinical Privileges.

## **3.9 INELIGIBILITY TO APPLY OR REAPPLY FOR APPOINTMENT OR CLINICAL PRIVILEGES FOLLOWING CERTAIN ACTIONS**

**3.9.1** A present or former Applicant or Practitioner who:

- 3.9.1.1** is the subject of Medical Staff or Board action (a) denying of application or reapplication for Staff Appointment or Clinical Privileges, or (b) suspending, revoking or terminating Staff Appointment or Clinical Privileges, or
- 3.9.1.2** has, following an automatic suspension or a recommendation by the MEC or Board that is unfavorable to him, (a) withdrawn his application or reapplication for Staff Appointment or Clinical Privileges, or (b) resigned, surrendered, or failed to reapply for Appointment or Clinical Privileges, or
- 3.9.1.3** has resigned employment or terminated his independent contractor relationship with CRMC or related entity while under investigation or in lieu of an investigation, shall be ineligible to apply or reapply for Staff Appointment and/or Clinical Privileges.
- 3.9.2** The period of ineligibility following an action described in Section 3.9.1.1 shall extend for at least twenty-four (24) months following completion or waiver of: (a) all hearing, appellate review, and other proceedings conducted by the Medical Staff and Board bearing upon the action, and (b) all judicial proceedings bearing upon the action. Provided, however, if a Practitioner's Clinical Privileges have been suspended for a fixed period of time, the Practitioner did not seek a hearing or appellate review, and the Practitioner's term of Appointment expires during the period of suspension, the period of ineligibility ends with the end of the suspension.
- 3.9.3** The period of ineligibility following an action described in Section 3.9.1.2 shall extend for at least twenty-four (24) months following the date of the withdrawal, resignation, surrender or, in the case of a failure to reapply, the expiration of Appointment or Clinical Privileges.
- 3.9.4** The period of ineligibility following an action described in Section 3.9.1.3 shall extend for at least twenty-four (24) months following the date of the resignation or termination of employment or the termination of the independent contractor relationship.
- 3.9.5** Subject to the requirements of MS Bylaw 6.2, following the twenty-four (24) month period of ineligibility, the former Applicant, Practitioner, or former Practitioner may submit an application for Staff Appointment and/or Clinical Privileges which shall be processed as an initial application. In addition to other requirements, the former Applicant, Practitioner or former Practitioner shall furnish evidence, and have the burden of establishing, that the basis for the earlier recommendation, action or investigation no longer exists and of rehabilitation or correction sufficient to assure the Staff and the Board that the prior issues will not recur. Further, such application shall not be considered complete unless the Applicant, Practitioner, or former Practitioner submits satisfactory evidence to the Credentials Committee

that he has complied with all of the specific requirements made of him, such as completion of training or proctoring conditions.

## **Article 4 CLINICAL PRIVILEGES**

### **4.1 EXERCISE OF CLINICAL PRIVILEGES**

Except as otherwise provided in Sections 4.4 and 4.5, a Practitioner shall be entitled to exercise only those Clinical Privileges specifically granted to him by the Board. Said Clinical Privileges must be within the scope of the license, certificate or other legal credentials authorizing him to practice in this state and consistent with any restrictions thereon. Regardless of the level of Clinical Privileges granted, each Practitioner must obtain consultation when necessary for the safety of his patients or when required by the MS Bylaws, MS Rules or the CRMC policies related to medical care.

### **4.2 DELINEATION OF CLINICAL PRIVILEGES IN GENERAL**

#### **4.2.1 Requests**

Each application and reapplication must include a completed form specifically delineating the Clinical Privileges desired by the Applicant. Requests for a modification of Clinical Privileges must be supported by documentation of additional training and/or experience supportive of the request.

#### **4.2.2 New Clinical Privileges**

Additional Clinical Privileges and classes of Clinical Privileges not presently listed on Staff Clinical Privileges checklist forms may be added upon determination by the Board that:

- 4.2.2.1** such Clinical Privileges are established as having a scientific basis;
- 4.2.2.2** the provision of such Clinical Privileges in CRMC is consistent with appropriate utilization of CRMC and its services;
- 4.2.2.3** such Clinical Privileges need to be performed in a hospital setting or that patients frequently require such services while hospitalized;
- 4.2.2.4** such Clinical Privileges would provide a needed patient service that is not already adequately provided for by

existing Practitioners or CRMC employees or independent contractors;

**4.2.2.5** adequate monitoring of such Clinical Privileges could be achieved by the Medical Staff without undue burden; and

**4.2.2.6** the provision of such Clinical Privileges would not unduly complicate patient care or expose CRMC or Medical Staff to liability.

### **4.2.3 Bases for Clinical Privileges Determinations**

Requests for Clinical Privileges shall be evaluated on the basis of the Applicant's education, training, documented experience in categories of treatment areas or procedures, the results of treatment, demonstrated competence, ability and judgment, physical and mental health status, emotional stability, ability to work harmoniously with others, references and other relevant information. The bases for Clinical Privileges determinations to be made in connection with periodic reapplication or otherwise shall include observation of the Applicant's clinical performance and the documented results of quality review, evaluation and monitoring activities required by these and the CRMC Bylaws to be conducted at CRMC. Clinical Privileges determinations shall also be based on pertinent information concerning the Applicant's clinical performance obtained from other sources, review of the records of patients treated in this or other hospitals, and reviews of the records of the Medical Staff which document the evaluation of the Practitioner's participation in the delivery of patient care in this and other institutions and health care settings where the Practitioner has exercised clinical privileges. This information shall be added to and maintained in the file established for each Practitioner for the MEC's review.

### **4.2.4 Procedure**

All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in this Article Four.

## **4.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES**

Requests for Clinical Privileges from dentists shall be processed in the manner specified in this Article. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted for other surgical services. Patients admitted for dental services by dentists must have a current history and physical examination at the time of admission done by a physician Practitioner. Such physician Practitioner shall be responsible for

the care of any medical problem that may arise during hospitalization and shall determine the risk, effect, and appropriateness of the proposed surgical procedure on the total health status of the patient. When significant medical abnormality is present, the final decision on whether to proceed with the surgery must be agreed upon by the dentist and by the physician Practitioner. The Chief of Surgery will decide the issue in case of dispute.

#### **4.4 TEMPORARY CLINICAL PRIVILEGES**

##### **4.4.1 Circumstances**

Upon the written concurrence of the Chief of Staff, the Chief Executive Officer, in his discretion, may grant temporary Clinical Privileges in the following circumstances:

- 4.4.1.1** Pendency of Application. Upon receipt of an application for Appointment including a request for temporary Clinical Privileges, an appropriately licensed Applicant whose complete application raises no concerns may be granted temporary Clinical Privileges for a period not to exceed sixty (60) days. In exercising such Clinical Privileges, the Applicant shall act under the supervision of the Chief of Staff and in accordance with the conditions specified in Section 4.4.2.
- 4.4.1.2** Care of Specific Patients. Upon receipt of a written request for specific temporary Clinical Privileges, an appropriately licensed Applicant of documented competence who is not an Applicant for Appointment may be granted temporary Clinical Privileges for the care of a specific patient. Such Clinical Privileges shall be exercised in accordance with the conditions specified in Section 4.4.2 and shall be restricted to the treatment of not more than one patient, after which such Applicant shall be required to apply for Staff Appointment and Clinical Privileges before being allowed to attend additional patients.
- 4.4.1.3** Locum Tenens. Upon receipt of a written request for specific temporary Clinical Privileges, an appropriately licensed Applicant of documented competence and who does not maintain a residence or office within a fifty (50) mile radius of CRMC may, without applying for Staff Appointment, be granted temporary Clinical Privileges to serve as locum tenens for a Physician Practitioner.

- a. Duration of Locum Tenens Clinical Privileges. The duration of such temporary Clinical Privileges during each Staff Year, is limited to either (but not both);
  - a. An initial period of no more than thirty (30) consecutive days, with such Clinical Privileges being subject to renewal for two successive periods of thirty (30) consecutive days, not to exceed his services as locum tenens; or
  - b. No more than forty-five (45) non-consecutive days during each Staff Year.
- b. Limitation of Locum Tenens Clinical Privileges.  
Locum tenens Clinical Privileges:
  - a. Shall be limited to treatment of the patients of the Practitioner for whom he is serving as locum tenens and providing call coverage for such Practitioner;
  - b. Shall be exercised in accordance with the conditions specified in Section 4.4.2; and
  - c. Shall not be entitled to admit his own patients to CRMC.

#### **4.4.2 Conditions**

Temporary Clinical Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Applicant's qualifications, ability and judgment to exercise the Clinical Privileges requested, and only after the Applicant has satisfied the professional liability insurance requirements of these Bylaws. Special requirements of consultation and reporting may be imposed by the Chief of Staff for the supervision of an Applicant who is granted temporary Clinical Privileges. An Applicant for temporary Clinical Privileges must acknowledge in writing that he has received, or has been given access to, and read the MS Bylaws and MS Rules, and that he agrees to be bound by the terms thereof in all matters relating to his temporary Clinical Privileges.

#### **4.4.3 Termination**

On the discovery of any information or the occurrence of any event the nature of which raises a question about a Practitioner's professional qualifications or ability to exercise any or all of the temporary Clinical Privileges granted, the Chief Executive Officer or the Chief of Staff may terminate any or all of such Practitioner's temporary Clinical Privileges; provided that where the life or well-being of a patient is determined to be endangered by continued treatment by that Practitioner with temporary Clinical Privileges, the termination may be

effected immediately by any person entitled to impose summary suspension under Article Five. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered where feasible in choosing the substitute Practitioner.

#### **4.4.4 Rights of a Practitioner with Temporary Clinical Privileges**

Temporary Clinical Privileges granted under this Article are for the purpose of accommodating special temporary needs of Applicants, Practitioners and their patients. Accordingly, neither the refusal to grant temporary Clinical Privileges nor the modification or termination of temporary Clinical Privileges shall entitle an affected Applicant or Practitioner to any rights under Article Six of these Bylaws.

#### **4.5 EMERGENCY CLINICAL PRIVILEGES**

In case of an emergency in which serious permanent harm or aggravation of an injury or disease is eminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any Practitioner is authorized and should be assisted to do everything possible to save the patient's life or to save the patient from serious harm, using every facility of the Hospital necessary (including the calling for any consultation necessary or desirable) to the degree permitted by the Practitioner's license, but regardless of Staff category or level of Clinical Privileges. When an emergency situation no longer exists, such Practitioner must request the Clinical Privileges necessary in order to continue to treat the patient. In the event such Clinical Privileges are denied or he does not desire to request Clinical Privileges, the patient shall be assigned to an appropriate Practitioner.

#### **4.6 DISASTER PRIVILEGES**

In the event there is a local or regional disaster which causes an activation of the emergency management plan AND there is an identified shortage of Practitioners to meet immediate patient care needs, either the Chief Executive Officer (including his designees and, in their absence, the Administrator on Call) or any Staff Officer can grant emergency privileges for voluntary practitioners based on emergency privileging procedures described in the MS Rules.

### **Article 5 CORRECTIVE ACTION**

#### **5.1 PURPOSE**

The purpose of this Article is to provide for action whenever there are grounds to suspect that a Practitioner has engaged in, made or exhibited acts, statements,

demeanor or personal or professional conduct, either within or outside of CRMC, which is, or is reasonably likely to be:

- a. detrimental to patients' safety or the delivery of appropriate patient care in CRMC;
- b. lower than the standards and aims of the Medical Staff or the qualifications, obligations or responsibilities of Practitioners;
- c. disruptive to the operations of CRMC; or
- d. contrary to or in disregard of these Bylaws, the Medical Staff Rules and Regulations, or CRMC policies related to the Medical Staff.

## **5.2 SUMMARY SUSPENSION**

### **5.2.1 Summary Suspension Generally**

The Credentials Committee and the Board shall each have the authority to summarily suspend the Clinical Privileges of a Practitioner whenever such action must be taken immediately to protect the life of any patient or to reduce the likelihood of injury or damage to the health or safety of any patient, employee or other person present in CRMC. The Practitioner shall be promptly notified of the summary suspension. Such summary suspension shall become effective immediately upon imposition. Since instances may occur where convening the entire committee may be impractical, and in the interest of time and immediate action, the authority of the Credentials Committee is hereby delegated to any two of the following individuals, acting in collaboration: the Chief of Staff, the Chairman of any Medical Staff Committee or Department, and the CEO. If any such individuals summarily suspend the Clinical Privileges of a Practitioner pursuant to such delegation, then such summary suspension shall be reviewed and ratified by the Credentials Committee within ten (10) days of the date of such summary suspension.

### **5.2.2 Provision for Patient Care**

Immediately upon the imposition of summary suspension, the Chief of Staff or Chairman of the Department shall have the authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in CRMC at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Practitioner.

### **5.2.3 The Investigation**

The Credentials Committee shall investigate the summary suspension as soon as is reasonably practical following the summary suspension. As a part of its investigation, the Credentials Committee shall afford the affected Practitioner an opportunity for an interview. At such interview he shall be informed of the general nature of the cause for the summary suspension, provided relevant information

relating to the investigation, and shall be invited to discuss explain or refute said causes. The interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws or the Medical Staff Rules and Regulations with respect to hearing and appeal shall apply thereto. A record of such interview shall be made by the Committee and included with its report to the Chief Executive Officer.

The Credentials Committee may name such non-voting, advisory members to assist in its investigation as it deems necessary. As part of its investigation, the Credentials Committee may require that the affected Practitioner submit to an examination to determine the Practitioner's current health status, if such is an issue in the investigation. During the interview, no attorneys will be present representing either the Credentials Committee or the affected Practitioner or Applicant.

#### **5.2.4 Further Corrective Action**

In addition to investigating the summary suspension, the Credentials Committee may, upon notice to the Practitioner, broaden the issues under investigation beyond those in the summary suspension, and may base its report, wholly or in part, upon issues not necessarily encompassed by the summary suspension.

#### **5.2.5 Report to the Credentials Committee**

As soon as is reasonably practical, but not later than fourteen (14) days following the date of the summary suspension, the Credentials Committee shall report to the Chief of Staff and the Chief Executive Officer the results of its investigation and shall take one or more of the following actions:

- a. make a finding clearing the Practitioner of the charges against him;
- b. direct that the summary suspension be terminated;
- c. direct that the summary suspension be continued pending further proceedings under Article Six of these Bylaws;
- d. issue a warning, a letter of admonition or a letter of reprimand to the Practitioner;
- e. impose terms of probation or requirements of prior or concurrent consultation or direct supervision;
- f. make a finding that there is sufficient evidence to warrant, and a recommendation of, suspension, reduction, limitation or termination of Staff Appointment and/or Clinical Privileges;
- g. direct that a part or all of the Practitioner's Clinical Privileges be suspended pending further proceedings under Article Six.

The report of the Credentials Committee to the Chief of Staff and Chief Executive Officer shall be accompanied by a written statement of the facts and reasons supporting the action of the Committee. Any minority views shall also be reduced to writing, referencing facts and reasons supporting such minority views, and

transmitted with the majority report. The Practitioner shall be furnished a copy of the report.

### **5.2.6 Report to the Board**

The Chief Executive Officer shall promptly forward the Credentials Committee's report to the Board in situations where the Committee's action on summary suspension is not "adverse" under Section 6.1.4. Section 6.1.4 provides that such non-adverse actions do not entitle the Practitioner to hearing, appellate review or other rights under Article Six. The Board may affirm or modify the action of the Committee, or may take action involving suspension, reduction or revocation of Staff Appointment and/or Clinical Privileges subject to any applicable hearing and appellate review as set forth in Article Six.

### **5.2.7 Adverse Action**

When the recommendation of the Credentials Committee or Board involves a continuation of summary suspension or other actions deemed adverse under Section 6.1.2, the provisions of Article Six shall apply, provided however, the action of the Credentials Committee or Board shall remain in full force unless and until modified by the hearing committee or the Board on appellate review.

### **5.2.8 Re-evaluation of Probation**

In the event that the action of the Credentials Committee is to impose terms of probation, the Committee shall re-evaluate its action and the performance of the Practitioner under the terms of the probation within a time prescribed by it, but in no event longer than six (6) months from its initial action and shall take such further action including extending the period of probation, as is then appropriate.

### **5.2.9 EXPIRATION OF TERMS**

In the event that the Credentials Committee members' term expire during an investigation of a summary suspension, said members shall continue to participate and act in such uncompleted matters with all powers and duties theretofore existing in said members until a final decision is made by the Committee on the summary suspension.

## **5.3 AUTOMATIC SUSPENSION**

### **5.3.1 Failure to Complete Medical Records**

Medical Staff Rules provide for automatic suspension of Clinical Privileges after warning of deficiency for failure to complete medical records, and confirmation by the Medical Executive Committee, within a prescribed time. Repeated violations

may also subject the Practitioner to further corrective action pursuant to Section 5.4.

### **5.3.2 Loss of License**

Expiration of a license or action by an appropriate licensing agency revoking or suspending or restricting the Practitioner's license shall result in the automatic suspension of all the Practitioner's Clinical Privileges consistent with the action of the licensing agency. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon the reinstatement of the Practitioner's license by the appropriate licensing agency and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges shall be considered by the Credentials Committee. Should the Credentials Committee decline to remove or revoke the automatic suspension, then the provisions of Article Six shall apply.

### **5.3.3 Failure to Maintain Professional Liability Insurance**

Failure to maintain required professional liability insurance shall result in the automatic suspension of all the Practitioner's Clinical Privileges. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon the reinstatement of the Practitioner's professional liability insurance (including not only current coverage but also continuous coverage for all claims arising out of acts which occur from the date the Practitioner was originally granted Staff Appointment and Clinical Privileges) and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges shall be considered by the Credentials Committee. Should the Credentials Committee decline to remove or revoke the automatic suspension, then the provisions of Article Six shall apply.

### **5.3.4 Loss of a DEA Number**

Whenever a Practitioner's DEA or other controlled substances number is revoked, suspended, or restricted, the Practitioner's Clinical Privileges to prescribe or order controlled substances is automatically suspended. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon the reinstatement of the Practitioner's DEA or other controlled substances number and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges shall be considered by the Credentials Committee. Should the Credentials Committee decline to remove or revoke the automatic suspension, then the provisions of Article Six shall apply.

### **5.3.5 Exclusion from State or Federal Healthcare Programs**

Whenever a Practitioner is suspended, excluded, or receives a payment suspension from the Medicare or Medicaid Programs, or listed on the General

Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs or otherwise listed by a governmental agency as excluded, disbarred, suspended, or otherwise ineligible to participate in federal or state healthcare programs, all of the Practitioner's Clinical Privileges and his Staff Appointment are automatically suspended. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon removal from such list and reinstatement in such programs and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges and Staff Appointment shall be considered by the Credentials Committee. Should the Credentials Committee decline to remove or revoke the automatic suspension, then the provisions of Article Six shall apply.

### **5.3.6 Failure to Maintain Current State and Federally Mandated Vaccinations or Test**

The Practitioner's Clinical Privileges shall be subject to suspension for failure to obtain and submit current documentation of any state or federally mandated test or vaccination required for providing services within a hospital. Upon receipt of the Practitioner's fulfillment of the state or federally mandated test or vaccination, the automatic suspension shall be immediately lifted.

### **5.3.7 Failure to Pay Fines, Dues, and Assessments**

Failure to pay Medical Staff fines, dues, and assessments as set by the MEC shall result in automatic suspension of the Practitioner's Clinical Privileges if, after receiving notice that the payment is due, the Practitioner fails to make payments within thirty (30) days.

## **5.4 PROFESSIONAL REVIEW ACTION**

### **5.4.1 Request for Corrective Action**

Whenever there is reason to believe that the activities or professional conduct of any Practitioner warrant corrective action, such corrective action may be requested by any officer of the Staff, the chair of the Performance Improvement Committee, the Chairman of a department, the CEO, or the Board. All requests for corrective action shall be in writing, shall be made to the Credentials Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Practitioner shall be furnished promptly with a copy of the request for corrective action.

### **5.4.2 Investigation by the Credentials Committee**

After receipt of a request for corrective action, the Credentials Committee shall conduct a preliminary review to obtain basic information related to the request for corrective action to determine whether an investigation should

commence. Should the preliminary review indicate the need for an investigation, the Credentials Committee shall initiate an investigation of the request for corrective action. The Practitioner shall be furnished notice that the Credentials Committee is investigating a request for corrective action within five (5) business days of the beginning of the investigation.

#### **5.4.3 Suspension or Restriction of Clinical Privileges During Investigation**

The Credentials Committee, upon notice to the Practitioner, may suspend or restrict all or part of a Practitioner's Clinical Privileges for a period of not longer than fourteen (14) days during which an investigation is being conducted to determine the necessity or appropriateness of corrective action. Such suspension or termination does not trigger the hearing and appeal procedures described in Article Six. The Practitioner shall be given the opportunity to discuss the suspension or restriction with the Credentials Committee within fourteen (14) days following such suspension or restriction. Such discussion, in the sole discretion of the Credentials Committee, may be treated as the interview described in Section 5.4.4 or as preliminary to such interview.

#### **5.4.4 The Investigation**

As a part of its investigation, the Credentials Committee shall afford the affected Practitioner an opportunity for an interview. At such interview, the Practitioner shall be informed of the general nature of the request for corrective action, provided relevant information relating to the investigation, and invited to discuss, explain or refute the issues presented by the request for corrective action or as otherwise determined by the Credentials Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws or the Medical Staff Rules with respect to hearing and appeal shall apply thereto. A record of such interview shall be made by the committee and included with this report to the Chief of Staff. The Credentials Committee may name such non-voting, advisory members to assist in its investigation as it deems necessary. As a part of its investigation, the Credentials Committee may require that the affected Practitioner submit to an examination to determine the Practitioner's current health status, if such is an issue in the investigation. During the interview, no attorneys will be present representing either the Credentials Committee or the affected Practitioner or Applicant.

#### **5.4.5 Further Corrective Action**

In addition to investigating the request for corrective action, the Credentials Committee may, upon notice to the Practitioner, broaden the issues under investigation beyond those in the request for corrective action, and may base its report, wholly or in part, upon the issues not necessarily encompassed by the request for corrective action.

#### **5.4.6 Report of the Credentials Committee**

As soon as practical, and within sixty (60) days after the date of the commencement of an investigation, the Credentials Committee shall report to the Chief of Staff and Chief Executive Officer the results of its investigation and shall take one or more of the following actions:

- a. make a finding clearing the Practitioner of the charges against him;
- b. issue a warning, a letter of admonition, or a letter of reprimand to the Practitioner;
- c. impose terms of probation or requirements of prior or concurrent consultation or direct supervision;
- d. make a finding that there is sufficient evidence to warrant, and a recommendation of, suspension, reduction, limitation or termination of Staff Appointment and/or Clinical Privileges;
- e. direct that a part or all of the Practitioner's Clinical Privileges be suspended pending further proceedings under Article Six.

The report of the Credentials Committee to the Chief of Staff shall include a written statement of the facts and reasons supporting the action of the Committee. Any minority views shall also be reduced to writing, facts and reasons supporting such minority views, and transmitted to the Chief of Staff with the majority report. The Practitioner shall be furnished a copy of the report.

#### **5.4.7 Report to the Board**

The Chief Executive Officer shall promptly forward the Credentials Committee's report to the Board where the Credentials Committee's action is not adverse under Section 6.1.4. Section 6.1.4 provides that such non-adverse actions do not entitle the Practitioner to hearing and appeal rights under Article Six. The Board may affirm or modify the action of the Credentials Committee, or may take action involving suspension, reduction or revocation of Staff Appointment and/or Clinical Privileges subject to any applicable hearing and appellate review pursuant to Article Six.

#### **5.4.8 Adverse Action**

When the recommendation of the Credentials Committee or Board involves actions deemed adverse under Section 6.1.2, the provisions of Article Six shall apply; provided however, that any action of the Credentials Committee or Board shall remain in full force unless and until modified by the hearing committee or the Board on appellate review.

#### **5.4.9 Re-evaluation of Probation**

In the event that the action of the Credentials Committee is to impose terms of probation, the Committee shall re-evaluate its action and the performance of the Practitioner under the terms of the probation within a time prescribed by it, but in no event longer than six (6) months from the initial action, and shall take such further action, including extending the period of probation, as it then appropriate.

#### **5.4.10 EXPIRATION OF TERMS**

In the event that the Credentials Committee members' terms expire during an investigation, said members shall continue to participate and act in such uncompleted matters with all power and duties theretofore existing in said members until the investigation is concluded and a final decision is rendered by the Credentials Committee.

### **5.5 IMPAIRED PHYSICIANS**

#### **5.5.1 Physical and Mental Examinations**

In order to promote the quality and safety of patient care at CRMC, whenever the physical, mental, and/or behavioral health status of a Practitioner or Applicant is called into question, the Credentials Committee, in its sole discretion and without triggering any rights under Article Five, may require such person to undergo a mental and/or physical health assessment by a Physician or at a facility selected by the Committee and under such circumstances (including direct report back to the Committee or its designee) as the Committee may establish.

Failure or refusal of the affected Practitioner to cooperate with the assessment may constitute grounds for denial of an application or reapplication or for corrective action. The results of such examination shall be reported to the Chair of the Committee and shall at a minimum address:

- 5.5.1.1** whether the Practitioner or Applicant has the ability to continue to provide Quality Patient Care and to otherwise meet the qualifications and fulfill the responsibilities of Staff Appointment and the specific Clinical Privileges granted him;
- 5.5.1.2** whether such ability is compromised by reason of illness, the use of alcohol, drugs, narcotics, chemicals or other substances, or as a result of any mental or physical condition; and
- 5.5.1.3** whether there should be any restriction, limitation or consultation requirement placed upon the Practitioner or Applicant's Staff Appointment or Clinical Privileges as a result of any such illness, use or condition.

On the basis of the report and any further investigation, the Credentials Committee may take further corrective action as appropriate, subject to the provisions of Articles Five and Six.

### **5.5.2 Specific Drug and Alcohol Screening**

Since instances may occur where there is reason to suspect that a Practitioner may be under the influence of drugs or alcohol and where convening the entire Credentials Committee may be impractical, and in the interest of time and immediate action, the authority of the Credentials Committee to require immediate drug or alcohol screening is hereby delegated to any one of the following individuals: the Chief of Staff, the Chair of any department, the Chair of the Credentials Committee, or the CEO. If any such individual requires a Practitioner to submit to an immediate drug or alcohol screening pursuant to such delegation, then such action shall be ratified by the Credentials Committee within ten (10) days of the date of such action.

Failure or refusal of the affected Practitioner to cooperate with the required screening may constitute grounds for denial of an application or reapplication or for corrective action. The results of such examination shall be reported to the Chair of the Credentials Committee and the Credentials Committee will investigate the matter and address:

- 5.5.2.1** the necessity and appropriateness of the requirement of the drug or alcohol screening;
- 5.5.2.2** the results of such screening;
- 5.5.2.3** whether the Practitioner or Applicant has the ability to continue to provide Quality Patient Care and to otherwise meet the qualifications and fulfill the responsibilities of Staff Appointment and the specific Clinical Privileges granted him;
- 5.5.2.4** whether such ability is compromised by reason of the use of alcohol, drugs, narcotics, chemicals or other substances, or as a result of any mental or physical condition; and
- 5.5.2.5** whether there should be any restriction, limitation or consultation requirement placed upon the Practitioner or Applicant's Staff Appointment or Clinical Privileges as a result of any such illness, use or condition.

On the basis of the screening and any further investigation, the Credentials Committee may take further corrective action as appropriate, subject to the provisions of Articles Five and Six.

## 5.6 INFORMAL ACTION

In certain circumstances where no summary suspension has been invoked pursuant to Section 5.2 and the Credentials Committee has not received a request for corrective action pursuant to Section 5.4.1 and the nature of an issue is such that it may appropriately be resolved through informal, person-to-person contact, the Credentials Committee may exercise its powers regarding review and evaluation of the quality of medical and hospital care through such informal means. Recognizing that such informal, person-to-person action may be more effective if performed by a person rather than a committee, the Credentials Committee delegates its power to take informal action in such instances to any one of the following individuals: the Chief of Staff, the Chair of any department, the Chair of any Staff Committee, and the CEO.

## Article 6 Fair Hearing Procedure

### 6.1 RIGHT TO HEARING AND APPELLATE REVIEW

Except as provided in Section 6.4, when any Applicant or Practitioner receives notice of any final adverse action under circumstances as defined in Section 6.3, he shall be entitled, upon timely and proper request, to the hearing and other procedures provided for in this Article Six.

### 6.2 ACTIONS AND PRACTITIONER'S RIGHTS

#### 6.2.1 Adverse Actions

The following recommendations or actions are adverse, if deemed final under Section 6.2.2, shall entitle the Practitioner to the rights provided for in this Article Six:

- a. denial of initial Appointment to the Medical Staff;
- b. denial of reapplication for Medical Staff Appointment;
- c. revocation of Medical Staff Appointment;
- d. denial of requested Clinical Privileges other than temporary privileges or clinical privileges not offered at CRMC at the time of application or for reasons as otherwise set forth in these Bylaws;
- e. reduction, revocation, or suspension of Clinical Privileges other than as provided in Section 6.2.3;
- f. summary suspension of Clinical Privileges; and-
- g. denial of reinstatement of Clinical Privileges following Leave of Absence.

### 6.2.2 Final Action

A recommendation or action listed in Section 6.2.1 is final only when it has been:

- a. recommended by the Credentials Committee pursuant to the Article Five and Article Six; or
- b. has been taken by the Board under circumstances where no prior right to request a hearing existed.

### 6.2.3 Actions Not Deemed Adverse

None of the following actions shall entitle an affected Applicant or Practitioner to any hearing, appellate review or other rights under this Article Six:

- a. the issuance of a warning, a letter of admonition, or a letter of reprimand;
- b. the imposition of terms of probation, preceptorship, monitoring, or pre- or post-case consultation requirements;
- c. the denial or termination of any temporary Clinical Privileges;
- d. automatic suspensions pursuant to Article Five;
- e. a suspension or restriction of Clinical Privileges for a period of not longer than fourteen (14) days during which an investigation is being conducted to determine the need for professional review action;
- f. change in, or denial of change in Medical Staff Category;
- g. other situations where these Bylaws and the Rules and Regulations specifically exclude hearing and appeal rights.

## 6.3 NOTICE OF ADVERSE ACTION

The CEO shall be responsible for giving prompt written notice of adverse action described in Section 6.2.1 by delivery to the affected Applicant or Practitioner either in person or by certified mail, return receipt requested. This notice shall:

- a. advise the Applicant or Practitioner of the action and of his right to request a hearing pursuant to the Bylaws and Rules and Regulations;
- b. specify that the Applicant or Practitioner has thirty (30) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Section 6.4;
- c. state that the failure to request a hearing within the time period and in the proper manner shall constitute a waiver of rights to any

- hearing or appellate review on the matter which is the subject of the notice;
- d. state that the Board is not bound by the adverse action that the Applicant or Practitioner accepts by virtue of his waiver, but may take any action, whether more or less severe, it deems warranted by the circumstances;
  - e. state the grounds upon which the adverse recommendations or actions are based;
  - f. state that upon receipt of his hearing request, the Applicant or Practitioner will be notified of the date, time and place of the hearing;
  - g. provide a summary of the Applicant's or Practitioner's rights at the hearing.

#### **6.4 REQUEST FOR HEARING**

The Applicant or Practitioner shall have thirty (30) days after receiving a notice under Section 6.3 to file a written request for a hearing. The request must be delivered to the CEO either in person or by certified mail, return receipt requested. In addition to requesting a hearing, such request must respond, point by point, to each finding or ground relied upon by the Credentials Committee in support of its actions or recommendation. This response must detail all reasons, from the affected Applicant's or Practitioner's point of view, each finding set forth by the Credentials Committee, and the action or recommendation itself, is in error.

#### **6.5 WAIVER**

##### **6.5.1 Failure to Request Hearing**

Failure of an Applicant or Practitioner to request a hearing within the time and in the manner specified in Section 6.4 shall be deemed to be a waiver of his right to any hearing or appellate review to which he might otherwise have been entitled.

##### **6.5.2 Incomplete Request**

In the event the affected Applicant's or Practitioner's request is incomplete, the CEO shall so notify him. Failure to furnish a complete request within five (5) business days after notice from the CEO shall be deemed to be a waiver of the Applicant's or Practitioner's right to any hearing or appellate review to which he otherwise may have been entitled, notwithstanding the earlier incomplete request.

##### **6.5.3 Effect of Waiver**

Any waiver shall apply only to the matters which formed the basis of the adverse action as set forth in the notice provided pursuant to Section 6.3. Upon waiver, the adverse action taken against the Applicant or Practitioner shall remain in effect pending the Board's final action in the matter. The Board is not bound by the previous adverse action that the Applicant or Practitioner has accepted by virtue of his waiver, but may take any action, whether more or less severe, it deems warranted by the circumstances. The CEO shall promptly notify the affected Applicant or Practitioner of his status and of the final action of the Board.

## **6.6 HEARING PREREQUISITES**

### **6.6.1 Notice of Time and Place of Hearing**

Within ten (10) days after receipt of a request for hearing from an Applicant or Practitioner entitled to the same, the CEO shall schedule and arrange for a hearing and shall notify the Applicant or Practitioner of the time, place and date of the hearing by written notice delivered to the affected Applicant or Practitioner either in person or by certified mail, return receipt requested. Ordinarily, the hearing date shall not be less than thirty (30) days from the date of the notice of the hearing by the CEO; provided, however, that the Applicant or Practitioner may request an earlier hearing date and, in such case, the hearing shall be held as soon as arrangements therefore may reasonably be made. Further, the hearing date shall not be more than one hundred eighty (180) days from the date of the notice of the hearing by the CEO; provided, however, that if the Applicant or Practitioner requests a delay of the hearing date beyond such date, the CEO, in his sole discretion, may extend such date.

### **6.6.2 Statement of Issues**

The notice of hearing shall contain a concise statement of the findings by the Credentials Committee resulting in the adverse action, a list by number of the specific or representative patient records in question, a list of witnesses (if any) expected to testify at the hearing and/or the other reasons or subject matter forming the basis for the adverse action or recommendation which is to be the subject of the hearing.

### **6.6.3 Composition of Hearing Committee**

- a. A hearing occasioned by an adverse action taken by the Credentials Committee shall be conducted by a hearing committee comprised of members of the Medical Staff. The hearing committee will consist of three (3) members of the MEC. The Chief of Staff shall serve as the chair of the hearing committee or, if the Chief of Staff has a conflict, will

- designate another member of the MEC to serve as the chair.
- b. Prior involvement of an MEC member in formulation of the adverse action which occasioned the hearing shall not bar participation as a hearing committee member.
  - c. The hearing committee shall exclude physicians who are in direct economic competition with the affected Applicant or Practitioner. Such exclusion may initially be determined by the CEO or by recusal of the competing physician.
  - d. The affected Applicant or Practitioner shall be notified of the names of the hearing committee members any may object to any committee member on the basis of such committee member being in direct economic competition. For purposes of this Article, direct economic competition means the physician practices in the same specialty or provides the same or similar services to substantially the same patient population. Any objection by the affected Applicant or Practitioner will be considered and ruled upon by the chair of the hearing committee, except when the objection is to the chair. If the objection is to the chair, the objection shall be ruled on by the hearing officer, if one is appointed. If no hearing officer is appointed, the objection shall be ruled on by the Chief of Staff-elect. Failure of the affected Applicant or Practitioner to object to any committee member within five (5) days of notice shall be deemed a waiver of his right to do so.
  - e. If following recusals, objections and exclusions, there are less than three (3) members of the MEC available to serve on a hearing committee, the CEO shall, in his discretion, select additional physician(s) to serve on the hearing committee. Such additional hearing committee members need not have Staff Appointment or Clinical Privileges at CRMC. Any determination by the CEO to name additional hearing committee members shall be final and binding on all parties.

#### **6.6.4 Authority of Hearing Committee**

The hearing committee shall have the authority to:

- a. Conduct a hearing, consider and receive evidence, and deliberate and reach a determination in the form of a final recommendation;
- b. Request that other Practitioners or outside experts examine questions within their respective specialties or questions

where a dispute exists between the position of the affected Practitioner and the adversary representative, and report to the hearing committee their opinions and the basis for those opinions;

- c. Direct the attendance and participation of witnesses, and the submission and introduction of documentary evidence, whether or not proffered by the adversary representative or the affected Applicant or Practitioner;
- d. Determine the weight to be accorded to evidence which is admitted; and,
- e. Take such other actions as will facilitate its business.

## **6.7 HEARING PROCEDURE**

### **6.7.1 Personal Presence**

The personal presence of the Applicant or Practitioner is required. An Applicant or Practitioner who fails, without good cause, to appear and proceed at the hearing shall be deemed to waive his rights in the same manner and with the same consequences as provided in Section 6.5.

### **6.7.2 Presiding Officer**

**6.7.2.1** Except as provided in Section 6.7.2.2, the chair of the hearing committee shall serve as the presiding officer over the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

**6.7.2.2** In lieu of the chair of the hearing committee serving as the presiding officer, the CEO, in his discretion, may appoint a hearing officer. If a hearing officer is utilized, he may be an attorney at law. He must be independent and may not be an employee of CRMC or be from a firm that regularly represents CRMC or the affected Applicant or Practitioner. The name of the hearing officer shall be provided to the affected Applicant or Practitioner who may object to the hearing officer due to a lack of independence. The chair of the hearing committee shall rule on any such objection.

**6.7.2.3** The presiding officer shall have the authority to:

- a. Establish the time, place, manner, and procedure for conducting the hearing, consistent with these Bylaws and the Medical Staff Rules;

- b. Clarify and narrow the issues;
- c. Hold a preliminary meeting with the parties for the purpose of clarifying issues, establishing procedures, or otherwise aiding the committee;
- d. Rule on the admissibility of evidence;
- e. Perform other tasks specified in the Bylaws and Rules and Regulations; and
- f. Otherwise preside over the hearing.

### **6.7.3 Committee Members**

Members of the hearing committee are actively encouraged to take a participatory role in the proceedings, to question witnesses, to call upon witnesses for information within their possession, to direct the submission of additional evidence and documentation, to question the adversary representative and the affected Applicant or Practitioner, and to see that the record contains all information which the committee considers necessary in order to reach a decision.

### **6.7.4 Representation of the Adverse Recommendation**

If the action which prompted the hearing was taken by a committee of the Medical Staff, it shall appoint one or more of its members or Practitioners to represent it at the hearing. If the action which prompted the hearing was taken by the Board, it shall appoint one or more of its members to represent it at the hearing. Such adversary representatives shall have the obligation to present the facts in support of the adverse action, to examine witnesses, and to otherwise participate fully in the hearing.

### **6.7.5 Representation of the Practitioner**

The affected Applicant or Practitioner is entitled to be represented by an attorney or other person of his choice.

### **6.7.6 Utilization of Attorneys**

While both the affected Applicant or Practitioner and the adversary representative are entitled to utilize an attorney at law to make statements, introduce evidence, examine witnesses, or otherwise serve as an advocate at the hearing, it is with the understanding that the hearings provided for in these Bylaws are for the purpose of resolving, on an intra professional basis, matters bearing on professional competency and conduct and are not a judicial forum. If attorneys are utilized by either the Applicant or Practitioner or the adversary representative, they should strive to facilitate, and not hinder, the hearing process in order that a prompt and fair decision may be made by the hearing committee. Accordingly, the

presiding officer and the hearing committee retain the right to limit the role of attorneys as participants in the proceedings.

The use of counsel by the affected Applicant or Practitioner is for the purpose of ensuring the affected Applicant or Practitioner has adequate representation, of his choice, during the fair hearing procedure. Counsel for the affected Applicant or Practitioner shall not be entitled, or allowed, to be present at any meeting of the Credentials Committee, or any other professional review body, in which the Credentials Committee, or other professional review body, does not have its counsel present.

It is understood that the Credentials Committee will need legal advice to ensure compliance with the federal and state statutes governing professional review matters. Nothing within these Bylaws, or the Rules and Regulations, prohibit the Credentials Committee, or any other professional review body, from utilizing an attorney and meeting with such attorney in private. Such meetings are subject to the attorney/client confidentiality and are absolutely privileged against any discovery by the affected Applicant or Practitioner.

The Credentials Committee has the discretion to select its counsel for advising on the imposition of an adverse action or defending the same, whether such counsel regularly represents CRMC, sometimes represents CRMC, or is wholly independent.

#### **6.7.7 Clarification of Issues**

- a. Outline of Case. At least fifteen (15) days prior to the scheduled date of a hearing, the affected Applicant or Practitioner and the adversary representative shall each submit an outline to the CEO for transmittal to the presiding officer, the committee and to the other party setting forth, so far as is then reasonably known:
  1. Issues which each party proposes to raise at the hearing.
  2. Witnesses whom each party proposes to call at the hearing and the subject or subjects on which such witnesses will testify.
  3. All written or documentary evidence which each party anticipates introducing as evidence at the hearing.
  4. A short summary of what the party expects to demonstrate at the hearing in support of its position.
  5. The specific result or results requested from the hearing committee.

- b. Pre-hearing Conference. At least five (5) business days before the scheduled commencement of the hearing, the presiding officer shall meet with the parties for the purpose of conducting a pre-hearing conference to discuss possible stipulations of facts, amendments to the grounds for action or the issues in dispute, and changes in the witness or evidence list of each party. Any further procedures established for the conduct of the hearing shall be explained at such time.

#### **6.7.8 Issues**

Once a hearing has been requested, the hearing committee shall not be bound by the statement of issues from Section 6.6.2 or 6.7.7. Instead, the committee may, upon advising the parties, broaden the issues under examination and may base its decision, wholly or in part, upon the resolution of issues not originally considered or listed.

#### **6.7.9 Rights of Parties**

During a hearing, each party may:

- a. Call and examine witnesses;
- b. Introduce exhibits;
- c. Cross-examine any witness on any matter relevant to the issues;
- d. Impeach any witness;
- e. Rebut any evidence;
- f. Request that the record of the hearing be made by use of a certified court reporter;
- g. Submit a written statement at the close of the hearing.

#### **6.7.10 Procedure and Evidence**

The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the existence of any common law or statutory rule which might make the evidence inadmissible over objection in civil or criminal actions. However, evidence related to the professional performance or behavior of another Practitioner and evidence of actions taken, or not taken, regarding the professional performance or behavior of another Practitioner is not relevant and is not admissible. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and such memoranda become part of the hearing record. The presiding officer may, but is not required to, order that oral

evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents.

#### **6.7.11 Order of Procedure**

The basic order of procedure for the hearing shall be as follows:

- a. First, the adversary representative shall present the facts in support of the adverse action, whether through testimony, written evidence or otherwise.
- b. Immediately following conclusion of the adversary representative's presentation (and any cross-examination by the affected Applicant or Practitioner), the affected Applicant or Practitioner shall testify in response to the facts and issues raised by the adversary representative, and shall be subject to cross-examination by the adversary representative. If the affected Applicant or Practitioner does not testify in his own behalf, he may be called at this time and examined as if under cross-examination.
- c. Upon conclusion of the affected Applicant or Practitioner's testimony, the affected Applicant or Practitioner may then call such other witnesses to testify as to matters which are relevant to the issues before the hearing committee.
- d. Upon conclusion of the affected Applicant or Practitioner's presentation (and any cross-examination by the adversary representative), the adversary representative may introduce rebuttal evidence.
- e. At any time during the procedure the hearing committee members may question witnesses.

#### **6.7.12 Official Notice**

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of Arkansas. Parties present at the hearing must be informed of the matters to be noticed, and those matters must be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute any officially noticed matter by evidence or by written or oral presentation of authority, in a manner to be determined by the hearing committee. The committee is also entitled to

consider all other information that can be considered under these Bylaws and Medical Staff Rules\_in connection with the credentials matter.

#### **6.7.13 Burden of Proof**

When a hearing relates to 6.2.1 a), b), d), or g), the Applicant or Practitioner shall have the burden of proving, by clear and convincing evidence, that the adverse action lacks any substantial factual basis or that such basis (or the action based thereon) is either arbitrary, unreasonable or capricious. When a hearing relates to 6.2.1 c), e), or f), the adversary representative shall have the initial obligation to present evidence in support of the adverse action, but the Applicant or Practitioner thereafter is responsible for supporting (by a preponderance of the evidence) his challenge that the adverse action lacks any substantial factual basis, or that such basis (or the action based thereon) is either arbitrary, unreasonable or capricious.

#### **6.7.14 Hearing Record**

A record of the hearing must be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may be later called upon to review the record and render a recommendation or decision in the matter. The hearing committee shall use a certified court reporter, to record the hearing proceeding.

Each party shall present a binder or digital file containing all documents that the party intends to utilize in the hearing. Each binder or digital file shall be considered part of the hearing record. All documents shall be date stamped and pre-marked with exhibit stickers.

The hearing committee, in its sole discretion, may require the parties to provide additional documents or written memorandum supporting arguments presented during the hearing. Such documents shall become part of the hearing record upon submission to the hearing committee.

The final record shall consist of the transcript, the documents contained in the binders or flash drives\_presented by each party, additional documentation as requested by the Credentials Committee, and the final report issued by the Credentials Committee.

The affected Applicant or Practitioner shall be entitled to a copy of the record upon request accompanied with payment of any reasonable charges associated with the preparation thereof.

#### **6.7.15 Postponement**

Postponement of a hearing shall be granted only by the hearing committee, in its sole discretion, upon a showing of good cause therefore.

#### **6.7.16 Presence of Committee Members and Vote**

A majority of the hearing committee members must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing, he may not participate in the final hearing committee vote until he certifies that he has reviewed the portion of the hearing record covering the portion of the hearing which took place during his absence. No committee member may vote by proxy. The CEO is entitled to and shall be present during all proceedings, deliberations and vote of the hearing committee as the duly authorized representative of the Board.

#### **6.7.17 Recesses and Adjournment**

The hearing committee may recess and reconvene the hearing without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

#### **6.7.18 Proposed Findings**

The hearing committee may direct the parties to submit proposed findings, referencing the hearing record, prior to conducting its deliberations. The presiding officer shall set the schedule for the submission of such proposed findings to the hearing committee.

### **6.8 HEARING COMMITTEE REPORT AND FURTHER ACTION**

#### **6.8.1 Hearing Committee Report**

The hearing committee shall make a written report of its findings and shall affirm, modify or reject the original adverse action. Such report shall include a statement of the basis for the action of the hearing committee. Such action by the hearing committee shall remain in full force and effect unless and until modified by the Board in the appellate review process, or otherwise as provided in the Bylaws and, Rules and Regulations. The hearing committee report shall be part of the hearing record along with all other documentation considered, which shall, in its entirety, be forwarded to the Board for final action.

#### **6.8.2 Notice**

The CEO shall promptly notify the affected Applicant or Practitioner of the hearing committee's action either by certified mail, return receipt requested, or personal delivery. This notice shall:

- a. Include a copy of the hearing committee report;
- b. Advise the affected Applicant or Practitioner of his right to request appellate review under Section 6.10 and of the waiver provisions of Section 6.10.2; and
- c. Be copied to the Chief of Staff and to the Board.

### **6.8.3 Effect of Report**

- a. Appellate Review: Action by the hearing committee involving any of the actions described in Section 6.2.1 shall entitle the affected Applicant or Practitioner to appellate review under Section 6.10 and 6.11. However, the action of the hearing committee shall remain in effect unless and until modified by the Board in the appellate review process or otherwise as provided in the Bylaws and Rules.
- b. Report to Board: Action by the hearing committee involving actions other than specified in Section 6.2.1, shall not entitle the affected Applicant or Practitioner to appellate review under Section 6.10 and 6.11. The hearing committee report shall be forward to the Board for final action. The Board may affirm, reject or modify the action of the hearing committee and make take any action, whether more or less severe, than the action of the hearing committee, the Board deems warranted by the circumstances. In the event such action by the Board results in an action specified in Section 6.2.1, the affected Applicant or Practitioner shall then be entitled to appellate review under Sections 6.10 and 6.11.

## **6.9 INITIATION AND PREREQUISITES OF APPELLATE REVIEW**

### **6.9.1 Request for Appellate Review**

The affected Applicant or Practitioner shall have seven (7) days after receiving a notice of adverse action under Section 6.9.2, which entitles him to appellate review, to file a written request for appellate review. The request must be delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a copy of the hearing committee report.

### **6.9.2 Waiver**

An affected Applicant or Practitioner who fails to request an appellate review within the time and manner specified in Section 6.10.1 shall be deemed to have waived any right to appellate review. Upon such waiver, the action of the hearing committee shall remain in effect pending the Board's final action in the matter. After submission of the final adverse action from the Medical Executive Committee to the Board, the Chair of the Hearing Committee shall be present at the Board meeting to answer any questions from the Board related to the final Report and Recommendation. The Board is not bound by the action of the hearing committee, but may take any action, whether more or less severe, it deems warranted by the circumstances. The Chief Executive Officer shall promptly notify the affected Applicant or Practitioner of his status and of the final action of the Board.

### **6.9.3 Notice of Time and Place for Appellate Review**

Within ten (10) days after receipt of a request for appellate review, the CEO shall schedule a date for appellate review, including the time and place for oral statements, if such have been requested by the Board, and the CEO, either by personal delivery or by certified mail, return receipt requested, shall notify the affected Applicant or Practitioner of the same. The date of appellate review shall ordinarily not be less than twenty-five (25) days, nor more than forty-five (45) days, from the date of receipt of the notice of request for appellate review, except that when the Practitioner requesting a review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made. These time periods are merely guidelines and are designed to assist the CEO and the Board in accomplishing their tasks. Consequently, they shall not be deemed to create any right for the affected Applicant or Practitioner to have appellate review scheduled within these precise periods.

### **6.9.4 Appellate Review Body**

The appellate review shall be conducted by the Board or a duly appointed subcommittee of the Board together with such other advisory non-voting members as the Board or such subcommittee may designate.

## **6.10 APPELLATE REVIEW PROCEDURE**

### **6.10.1 Nature of the Proceedings**

The appellate review proceedings are a review based upon the hearing record and, if requested by the Board, any oral or written statements. In reaching its decision, the appellate review body is limited to consideration of:

- a. Whether or not the Bylaws and the Rules and Regulations, have been followed;
- b. Whether or the decision of the hearing committee was based upon substantial evidence of record; and
- c. Whether or not the hearing committee's decision was a reasonable one in light of CRMC's duty to the public.

#### **6.10.2 Written Statements**

If the Board has requested the parties submit a written statement, the affected Applicant or Practitioner shall have thirty (30) days from the date of his request for appellate review in which to submit to the CEO, either in person or by certified mail, return receipt requested, a written statement detailing the factual and procedural matters with which he disagrees, specifying the particular reasons for such disagreement. In order to assist the appellate review body in its review, the written statement should specifically reference applicable portions of the hearing record. This written statement may cover any matters raised at any step in the procedure to which the appeal is related and legal counsel may assist in its preparation. A similar statement supporting the action of the hearing committee and replying to the statement of the affected Applicant or Practitioner shall be submitted on behalf of the hearing committee within thirty (30) days from the date of receipt of the request for appellate review by the CEO. Such written statements shall be submitted to the appellate review body by the CEO, and the CEO shall provide copies thereof to the affected Applicant or Practitioner or the hearing committee representative, as appropriate.

#### **6.10.3 Oral Statements**

The Board may choose, in its discretion, to allow the affected Applicant or Practitioner to make an oral statement. If the opportunity to make an oral statement has been afforded the affected Applicant or Practitioner, he shall be present at the appellate review proceedings and shall be permitted to speak himself or by his representative against the adverse action. The affected Applicant or Practitioner shall be subject to examination by any member of the appellate review body. The hearing committee shall also be represented by an individual who shall be permitted to speak in favor of the adverse action and who shall answer questions put to him by any member of the appellate review body. Both the affected Applicant or Practitioner and the representative of the hearing committee, in their own discretion, may utilize the services of an attorney-at-law as an advocate at such oral presentations. No additional evidence may be offered at such oral presentation.

#### **6.10.4 Consideration of New or Additional Matters**

New or additional matters or evidence not raised or presented during the original hearing or in the hearing committee report and not otherwise reflected in the record may not be introduced at appellate review unless expressly requested by the appellate review body and only upon a determination that such matters or evidence could not have been discovered in time for the initial hearing.

#### **6.10.5 Presiding Officer**

The chair of the appellate review body shall serve as the presiding officer and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

#### **6.10.6 Presence of Members**

A majority of the appellate review body must be present through the review and deliberations.

#### **6.10.7 Recesses and Adjournment**

The review body may recess and reconvene the proceedings without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if any, the appellate review shall be closed. The appellate review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.

#### **6.10.8 Action Taken**

The appellate review body may affirm, modify or reverse the adverse result or action, or in its discretion, may refer the matter back to the hearing committee for further review and recommendation within a time period set by the appellate review body. Within a reasonable time following completion of appellate review, the Board shall take action and the Board's action shall be immediately effective and final, and shall not be subject to further hearing or appellate review.

#### **6.10.9 Notice of Final Action**

The CEO shall promptly send written notice of the final action of the Board to the affected Applicant or Practitioner either by personal delivery or by certified mail, return receipt requested. Such notice shall include a statement of the basis of the Board's action.

### **6.11 COMPLETION OF HEARING AND APPELLATE REVIEW PROCESS**

The hearing and appellate review process provided herein shall not be deemed to have been concluded until all of the procedural steps provided in this Article have either been completed or waived.

#### **6.12 NUMBER OF HEARINGS AND REVIEWS**

Notwithstanding any other provision of the Bylaws or the Rules, no Applicant or Practitioner shall be entitled as a right to request more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of an adverse action taken against him.

#### **6.13 BOARD COMMITTEE ACTION**

Where permitted by the CRMC Bylaws, all action required of the Board may be taken by a committee of the Board duly authorized to act.

#### **6.14 RELEASE**

By requesting a hearing or appellate review under this Article, an Applicant or Practitioner agrees to be bound by the provisions of the Bylaws and Rules regarding the Fair Hearing Procedure and immunity from liability.

#### **6.15 EXCEPTIONS TO HEARING AND APPELLATE REVIEW PROCEDURES**

The hearing and appellate review provisions of this Article Six do not apply to:

##### **6.15.1 Voluntary Resignation or Failure to Reapply**

The expiration or other termination of Appointment or Clinical Privileges due to the Practitioner's voluntary resignation, failure to reapply, or failure to request reinstatement following a leave of absence.

##### **6.15.2 Outpatient Courtesy Staff**

Denial, non-renewal, limitation or termination of Outpatient Courtesy Appointment and related Clinical Privileges.

##### **6.15.3 Contracted Physicians**

Any automatic termination of Appointment or Clinical Privileges described in Section 3.5.16.2.

##### **6.15.4 Failure to Meet Preliminary Eligibility Requirements**

The failure of a person to establish that he meets the preliminary eligibility criteria in Basic Requirements for Appointment.

#### **6.15.5 Temporary Clinical Privileges**

Denial, non-renewal, limitation or termination of Temporary Clinical Privileges.

#### **6.15.6 Automatic Suspension**

Automatic suspension of Clinical Privileges described in Section 5.3.

#### **6.15.7 Suspension or Restriction of Clinical Privileges During Investigation**

Suspension or restriction of Clinical Privileges for up to fourteen (14) days while an investigation is pending.

#### **6.15.8 Other Circumstances**

The hearing and appellate review provisions of this Article Six do not apply or are limited, where other circumstances are specified in the Bylaws and, the Rules and Regulations.

### **6.16 ALLIED HEALTH PROFESSIONALS**

Nothing contained in these Bylaws shall be interpreted to entitle an AHP to the corrective action, hearing or appellate rights otherwise set forth herein. However, an AHP shall have the right to challenge any action that would constitute grounds for a hearing, by filing a written grievance with the Chairman of the Department to which the AHP has been assigned and in which he has the Clinical Privileges, in question, within fifteen (15) days of such action. Upon receipt of such a grievance, the Chairman of the Department shall initiate a careful investigation and afford the affected AHP an opportunity for an interview before an ad hoc committee appointed by said Chair. The interview shall not constitute the same type of "hearing", as is established in the Fair Hearing Procedure and need not be conducted according to the procedural rules applicable with respect to such hearings. Before the interview, the AHP shall be informed of the general nature of the circumstances giving rise to the proposed action, and at the interview, the AHP may present information relevant thereto. A report of the findings and recommendations shall be made by the Chairman of the Department to the Credentials Committee which shall act thereon. The action of the Credentials Committee shall be final, subject to approval of the Board.

## **Article 7 Medical Staff Organization**

### **7.1 MEDICAL STAFF OFFICERS**

#### **7.1.1 Officers**

The elected officers of the Medical Staff shall be:

- a. Chief of Staff (COS)
- b. Chief of Staff Elect (COSE)

#### **7.1.2 Election and Tenure**

The COS and the COSE shall be elected at the annual Staff meeting every two (2) years. Election of officers shall occur at the annual Medical Staff meeting. The offices will be assumed on January 1 of the year following their election. Term of office will be two (2) years.

The COS will select a nominating committee of three Active Staff members prior to the annual meeting. One shall be the Immediate past Chief of Staff. The proposed slate of nominees shall be distributed to the Active Staff members at least thirty (30) days prior to the election. Any Active Staff member may, in writing and with the nominee's approval, submit additional nominees to the COS at least fifteen (15) days prior to the election; the final slate will be distributed at least seven (7) days prior to the election. Election shall be by majority vote of those attending. Voting by proxy shall not be permitted. If no candidate receives a majority vote on the first ballot, a runoff election shall be held between the two candidates receiving the highest number of votes. The Board shall have final approval of all officers.

#### **7.1.3 Qualifications of Officers**

At the time of nomination and election, each officer must meet each of the following qualifications:

- a. Must be an appointee of the Active Medical Staff for a period of at least five (5) years;
- b. Must be in good standing at the time of election and remain in good standing as an appointee of the Active Medical Staff during their term of office;
- c. Must regularly practice at CRMC, as defined by the Active Medical Staff Category;
- d. Must have served as a member of the MEC;
- e. Must be willing and able to discharge the duties of the office; and
- f. Meet such other qualifications that the MEC adopts by Rule.

Failure to maintain such qualifications shall immediately create a vacancy in the office involved.

#### 7.1.4 Duties of Officers

- a. COS shall provide leadership and guidance to the Medical Staff and promote effective communication among the Medical Staff, the MEC, Administration, and the Board. This individual serves as the Chief Medical Officer of the organization and reports directly to the MEC and the Board. As required by office, the COS must:
  1. Coordinate the activities and concerns of Administration, Nursing Service, the Board, and patient care services with those of the Medical Staff.
  2. Communicate and represent the opinion, policies, concerns, needs, and grievances of the Medical Staff to the Board, CEO, and other appropriate individuals.
  3. Enforce the Medical Staff Bylaws and Rules and Regulations.
  4. Assist in securing and maintaining appropriate accreditation.
  5. Ensure the Medical Staff compliance with procedural safeguards in all instances where corrective action has been recommended in regard to a practitioner.
  6. Call, preside at, and develop the agenda for all Medical Staff meetings.
  7. Serve as Chairman of the MEC, as an ex-officio member of the Board, and as an ex-officio member of all other Medical Staff committees.
  8. Consult with the COSE on matters of special concern to Medical Staff members.
  9. Appoint committee members and chairman, all of whom are members of the active Medical Staff in good standing.
  10. Comply with all other duties assigned to the COS in these Bylaws and the Rules and Regulations.
- b. The COSE shall:

1. Assist in performing the functions of the COS.
  2. Provide continuity of leadership when the COS is absent or otherwise unable to perform his assigned functions.
  3. As a member of the MEC, the COSE serves as the communications officer and is responsible for dissemination of matters of importance to the Medical Staff in accordance with Rules and Regulations.
  4. Comply with all other duties assigned to the COSE in these Bylaws and the Rules and Regulations.
- c. The Immediate Past Chief of Staff shall be a non-voting member of the MEC and shall have the primary responsibilities of supporting the COS in the smooth transition of duties and of advising the COS and the MEC on issues which continue across terms or are similar in nature to those addressed during his term as COS. He shall be a member of the Performance Improvement Committee.

#### **7.1.5 Vacancies in Office**

If a vacancy occurs in the office of the Chief of Staff, the Chief of Staff-Elect shall serve out the remaining term. Other vacancies in office shall be filled by vote of the MEC.

#### **7.1.6 Resignation and Removal from Office**

- a. An officer may resign at any time by giving written notice to the MEC, effective on the date of receipt or at any later-specified time. Should the Immediate Past Chief of Staff resign, the office shall remain vacant.
- b. An officer may be removed for physical or mental impairment or for failure to meet and carry out the requirements and responsibilities outlined in the Bylaws and the Rules and Regulations. Such removal may be effected by 2/3 of voting members of the MEC or by secret vote of two-thirds of the Active Medical Staff present at a special Medical Staff meeting called for that purpose and where a quorum is present. Removal of an officer becomes effective when ratified by the Board.

## **7.2 DEPARTMENTS**

### **7.2.1 Organization**

The Medical Staff shall be organized into Departments reflecting clinical specialties. Each department shall meet every other month. A permanent record of the proceedings and actions of each department shall be maintained.

### **7.2.2 Assignment to Department**

Each Medical Staff member shall be assigned to a Department but may be granted Clinical Privileges in one or more departments if appropriately qualified. The exercise of Clinical Privileges within a Department shall be subject to Medical Staff Rules and Regulations and to the authority of the Department Chairman.

### **7.2.3 Qualifications, Selection and Tenure of Clinical Department Officers**

Each Clinical Department shall have a Chairman and such other officers as may be determined by the Department. The Chairman shall be elected for a two-year term by the department, subject to confirmation by the MEC and the Board. Qualification to serve as Chairman include:

- 7.2.3.1** have been a Practitioner with Active Staff Appointment for at least five (5) years;
- 7.2.3.2** is Board certified or a comparable certification;
- 7.2.3.3** have primary affiliation with the Department;
- 7.2.3.4** have a significant presence at CRMC, as determined by the Department, through both clinical and administrative processes; and
- 7.2.3.5** have demonstrated continuing interest in the affairs of the Department and the Medical Staff.

### **7.2.4 Responsibilities of Department Chairmen**

Department Chairman are responsible for the following:

- 7.2.4.1** to be accountable for all clinical and administrative activities within his department;
- 7.2.4.2** to be a member of the MEC, participating by regular attendance and giving guidance to the committee on the overall medical policies of CRMC and making specific recommendations and suggestions regarding his department in order to assure quality patient care;

- 7.2.4.3** to recommend to the Medical Staff the criteria for Clinical Privileges in the department;
- 7.2.4.4** to maintain continuing surveillance of the professional performance of all practitioners with Clinical Privileges in his department and report regularly thereon to the MEC;
- 7.2.4.5** to be responsible for enforcement of the Bylaws of CRMC and the Medical Staff Bylaws, Procedures and Rules and Regulations;
- 7.2.4.6** to be responsible for implementation within his department of actions taken by the MEC and communication to and from the MEC, Board and between departments;
- 7.2.4.7** to transmit to the Credentials Committee his Department's recommendations concerning the Medical Staff Category, reappointment and delineation of Clinical Privileges for all practitioners applying for or exercising privileges with the department;
- 7.2.4.8** to be responsible for teaching, education, development of clinical criteria and peer review activities, assuring that appropriate actions are taken regarding adverse peer review findings, monitoring and evaluation of care;
- 7.2.4.9** to participate in every phase of administration of the department through cooperation with Nursing Service and Administration in matters affecting patient care;
- 7.2.4.10** to authenticate minutes, resolutions and other Department documents and refer pertinent information and actions to other appropriate Medical Staff Committees;
- 7.2.4.11** to develop and implement Rules and Regulations that guide and support the provision of services;
- 7.2.4.12** to recommend a sufficient number of qualified and competent persons to provide care;
- 7.2.4.13** to determine the qualifications and competence of department or section personnel who are not licensed independent practitioners and who provide patient care;
- 7.2.4.14** to continuously assess and improve the quality of patient care and services provided;
- 7.2.4.15** to maintain quality control programs;

**7.2.4.16** to orient and encourage the continuing education of all persons in the department;

**7.2.4.17** to recommend space and other resources needed by the department to administration and the Board.

**7.2.4.18** to do all other things as reasonably requested by the COS, CEO or Board;

**7.2.4.19** to review contract services not provided by the Department;

**7.2.4.20** to be responsible for the integration of services within the Department;

**7.2.4.21** to be responsible for the integration of services with other Departments;

**7.2.4.22** to assess and recommend to the Hospital Board off-site sources of care.

## **7.2.5 Resignation or Removal of Department Chairman**

- a. A Department Chairman may resign at any time by giving written notice to the MEC, effective on the date of receipt or at any later-specified time.
- b. A Department Chairman may be removed for physical or mental impairment or for failure to meet and carry out the requirements and responsibilities outlined in the Bylaws and the Rules and Regulations. Such removal may be effected by 2/3 of voting members of the MEC or by secret vote of two-thirds of the Department present at a special Departmental meeting called for that purpose. Removal of a Department Chairman becomes effective when ratified by the Board.
- c. If a vacancy occurs as a result of this provision, the vacancy shall be filled by the vote of the department as set forth in Section 6.2.3.

## **7.2.6 Sections**

At the request of the Department Chairman, on behalf of his Department and upon approval by the MEC, a group of physicians with common interests may be formed to meet together informally. They shall have no responsibilities apart from those of the organized Department, but may be asked for input from the Department Chairman in matters involving that particular section.

### 7.2.7 Meetings

Departments shall meet every other month at the time determined by the respective department.

## 7.3 COMMITTEES

### 7.3.1 MEC

#### a. Composition

The MEC shall be a standing committee and shall be composed of the following:

- COS
- COSE
- Chairmen of Departments- elected by each department
- Two members at large, one from each department of Specialty Care and Primary Care--elected by department itself
- IPCOS (ex-officio, non-voting)
- CMO (Non-voting)
- CEO (Non-voting)

All voting members of the MEC are physicians on the Active Medical Staff at CRMC.

#### b. Meetings

The MEC shall meet monthly or as often as is deemed necessary by the COS to carry out its duties. At least two voting members of the MEC shall be present to constitute a quorum. A permanent record of its proceeding and actions shall be maintained.

#### c. The duties of the MEC shall be:

1. To represent and to act on behalf of the Medical Staff.
2. To coordinate the activities and general policies of the departments and Medical Staff committees.
3. To receive, review and act upon committee and department reports and recommendations.
4. To implement the Bylaws and Rules and Regulations of the Medical Staff.
5. To provide liaison between the Medical Staff and the CEO and the Board.
6. To recommend action to the CEO on matters of medico administrative nature.
7. To make recommendations directly to the Board for its

approval pertaining to:

- A. The structure of the Medical Staff.
  - B. The mechanism used to review credentials and to delineate individual Clinical Privileges.
  - C. The mechanism by which appointment to the Medical Staff may be suspended, reduced or revoked.
  - D. The mechanism for fair-hearing procedures.
  - E. The organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities.
  - F. Appointment, reappointment and delineation of Clinical Privileges for the Medical Staff.
8. To fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients of CRMC in conjunction with other Staff Committees, to be responsible for reviewing and evaluating the quality of medical or hospital care provided at CRMC.
  9. To ensure the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of CRMC.
  10. To provide for the preparation of all meeting programs.
  11. Review of quality assurance monitoring and evaluation activities with reporting to the Board on a monthly basis.
  12. To report at the annual Medical Staff meeting.
  13. To keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.
  14. To assess and evaluate problems associated with impaired practitioners.
  15. To review Bylaws and Rules and Regulations annually.
  16. To communicate to the Medical Staff the activities of the MEC.
  17. To orient the leaders of the Medical Staff.
  18. Approve appointment and reappointment and delineation of Clinical Privileges for the Medical Staff and AHPs and recommend to the Board.
  19. To carry out such other functions as required by the Staff Rules and Regulations.
- d. Any member of the Medical Staff shall have the right to appear before the MEC for the purpose of expressing any grievance, concern, or recommendation relative to Medical Staff functions which has not been addressed to the member's satisfaction elsewhere. This request to appear shall be made in writing.
  - e. No member of the Active Staff is ineligible for membership on the MEC solely because of his professional discipline or specialty.

**7.3.2** There shall be standing and ad hoc committees of the Medical

Staff. Functions of these committees are outlined in the Rules and Regulations.

## **7.4 MEETINGS**

### **7.4.1 Medical Staff Meeting**

An annual meeting of the Medical Staff shall be held in October of each year. Written notice shall be sent to each member and conspicuously posted. The purpose of the meeting shall be to report on the activities of the staff and to conduct other business as may be on the agenda. A quorum shall consist of the Medical Staff present. Written minutes of all meetings shall be prepared.

### **7.4.2 Special Meetings**

The COS may call a special meeting of the Medical Staff at any time or at the request of the Board. The COS shall call a special meeting within seven (7) days after receipt of a written request for same signed by any five (5) Active Staff members and stating the purpose of the meeting. The COS shall designate the time and place of the meeting. Written notice stating the time, place and purpose of any special meeting shall be conspicuously posted and sent to each member on the Medical Staff at least seven (7) days prior to the meeting date. A quorum shall consist of the Medical Staff present. No business shall be conducted at any special meeting except that stated in the notice of such meeting.

### **7.4.3 Attendance Requirements**

It shall be expected that all Medical Staff Committee appointed members attend at least fifty percent (50%) of the meetings scheduled. In the event of a display of lack of interest Shown by absenteeism, the MEC with a majority vote may remove these MEC or Credentials appointees, Department Chairmen and request the affected Department or Committee to replace them.

### **7.4.4 Participation by the CEO**

The CEO or his designee may attend any Medical Staff, Committee or Department meeting but shall not vote on any items put forth.

### **7.4.5 Rights of Ex-Officio Members**

Except as otherwise herein provided, ex-officio members of a Committee shall have all the rights and privileges of regular members except they shall not vote.

## **7.5 RESIGNATION AND REMOVAL OF AT-LARGE MEMBERS**

- a. An at-large member may resign at any time by giving written notice to the MEC, effective on the date of receipt or at any later-specified time.
- b. An at-large member may be removed for physical or mental impairment or for failure to meet and carry out the requirements and responsibilities outlined in the Bylaws the Rules and Regulations. Such removal may be effected by 2/3 of voting members of the MEC. Removal of an at-large member becomes effective when ratified by the Board.
- c. If a vacancy occurs in an at-large position, the vacancy shall be filled by vote of the MEC.

## **Article 8 Amendments**

### **8.1 BYLAWS**

#### **8.1.1 General Principles**

It shall be the responsibility of the MEC to annually review these Bylaws and to recommend amendments thereto when appropriate. This responsibility shall be exercised in good faith and in a timely, reasonable and responsible manner, with the goal of promoting staff unity and quality patient care. Bylaws and Rules and Regulations and their amendments shall be effective when approved by the Board.

#### **8.1.2 Methods**

- a. A proposed amendment may originate from the MEC, from a Department, from any Committee, or Practitioner of the Medical Staff, but must first be referred to the MEC for review and discussion; it will then be transmitted to the Medical Staff for a vote at any regular or special meeting. The proposed amendment must be distributed at least twenty-one (21) days prior to the staff meeting at which the vote will be taken. To be adopted, two-thirds of those attending must vote affirmatively. If passed, the MEC will recommend that the Board accept and approve the proposed amendment.
- b. Alternatively, voting may be conducted by mailed ballot. Each ballot shall contain the following options: a) for the proposed change b) against the proposed change c) request for an open meeting of the Medical Staff to discuss the proposed change. The ballot may be conducted electronically. Active Medical Staff members must return their ballots within two weeks to the Medical Staff Office to be reviewed by the MEC. For adoption, 50% of the ballots must be returned with two-thirds of those ballots returned in the affirmative.

- c. If the Medical Staff fails, after appropriate notice from the Board, to exercise these responsibilities during a reasonable time frame, the Board may resort to its own initiative in formulating, reviewing or amending these Bylaws. In such event, Medical Staff views and recommendations will be considered by the Board during its deliberations.

## **8.2 RULES AND REGULATIONS**

The Medical Staff Rules and Regulations may be amended or altered by the MEC. This action shall occur after two (2) readings at the MEC with affirmative votes at both meetings and at least one month between the meetings during which time the proposed changes shall be circulated to the Active Medical Staff for comment. Such changes shall become effective upon approval of the Board.

## **8.3 COMMUNICATION OF CHANGES TO MEDICAL STAFF**

When changes are made in the Bylaws and Rules and Regulations, these changes shall be made available to the Medical Staff in writing through the COS or his designee.

## **8.4 RESTRICTION OF UNILATERAL AMENDMENT**

These Bylaws, together with the Rules and Regulations shall not be changed unilaterally by the Medical Staff nor the Board, without following the provisions in this Article Eight.

# **Article 9 Immunity and Releases**

## **9.1 AUTHORIZATION AND CONDITIONS**

By applying for appointment, reappointment, change in staff status or Clinical Privileges or by exercising Staff Appointment or Clinical Privileges or prerogatives of membership the Applicant or Practitioner:

- 9.1.1** agrees to abide and be bound by the Bylaws and Rules and Regulations of the Medical Staff and CRMC;
- 9.1.2** authorizes CRMC, Medical Staff and the representatives to consult with any person, hospital, medical staff, institution or other entity with whom the Applicant or Practitioner has been associated or who may have information bearing on his professional competence, ethics, character, health status and other qualifications;
- 9.1.3** authorizes the release to CRMC, Medical Staff and their representatives of any and all records as may be appropriate to the evaluation of the

Applicant's or Practitioner's professional competence, ethics, character, health status and other qualifications including medical records and information from other hospitals or entities which might otherwise be considered confidential or privileged against release by federal or state law or regulation; and

- 9.1.4** authorizes CRMC, Medical Staff and their representatives to communicate to other hospitals, persons, institutions or other entities with a legitimate interest in any information concerning his professional competence, ethics, character, health status and other qualifications, which the hospital may have or acquire.
- 9.1.5** authorizes CRMC, Medical Staff and their representatives to solicit and act upon information from third parties.
- 9.1.6** acknowledges that the provisions of this Article are express conditions to his application for, or acceptance of, Staff Appointment and Clinical Privileges and to the continuation of such Appointment and his exercise of Clinical Privileges at CRMC.

## **9.2 IMMUNITY FROM LIABILITY**

No Representative of CRMC or Staff shall be liable to an Applicant or Practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his duties as a Representative, if such Representative acts without malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

No Representative of CRMC or Staff and no Third Party shall be liable to an Applicant or Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a Representative of CRMC or Medical Staff or to any other health care facility or organization of health professionals concerning an Applicant or Practitioner, provided that such Representative or Third Party acts without malice and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

## **9.3 ACTIVITIES AND INFORMATION COVERED**

### **9.3.1 Activities**

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with CRMC's or any

other health care facility's or organization's activities concerning, but not limited to:

- a. Applications for Appointment or Clinical Privileges;
- b. periodic reapplications for Appointment or Clinical Privileges;
- c. corrective or disciplinary action;
- d. hearings and appellate reviews;
- e. quality assurance and quality assessment and improvement program activities;
- f. utilization reviews;
- g. claim reviews;
- h. malpractice loss prevention and risk management;
- i. other CRMC and Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct; and
- j. reports made pursuant to applicable state or federal law.

### **9.3.2 Information**

Information referred to in this Article may relate to an Applicant's or Practitioner's professional qualifications, clinical ability, judgement, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

## **9.4 SPECIAL LITIGATION COVENANT**

### **9.4.1 Each Applicant and each Practitioner covenants and agrees that:**

- a. if he sues any Representative and/or CRMC; and
- b. the relief and/or damages requested by him in such suit are not granted or substantially granted by final judgment, then he shall promptly reimburse CRMC and all Representatives who are defendants in such suit for their reasonable attorneys' fees and other reasonable expenses incurred in defense of such suit.

### **9.4.2 Jurisdiction and Venue**

Each Applicant and Practitioner also covenants and agrees that any lawsuit brought against any Representative and/or CRMC shall be brought either in a Circuit Court located in Faulkner County, Arkansas or United States District Court located in the Eastern District of Arkansas.

### **9.4.3 Purpose of Covenant**

While neither the Board, the Medical Staff, nor CRMC has any desire to inhibit the legitimate exercise and pursuit of legal rights by Applicants or Practitioners, this special covenant has been made a part of the Bylaws for the following

reasons:

- a. to encourage the Medical Staff issues to be resolved on a peer-to-peer basis rather than in court;
- b. to provide additional protection to Representatives and thereby encourage their participation in Medical Staff activities; and
- c. to reduce the costs of delivering health care to patients by discouraging unnecessary litigation.

**9.5 PEER REVIEW CONFIDENTIALITY**

Proceedings, exhibits, testimony, deliberations, reports and records of any Organized Committee, Department or other group of the Medical Staff of CRMC, set forth in these Bylaws or in Rules and Regulations involving the evaluation of the quality of medical or hospital care which include peer review issues, are absolutely privileged and strictly confidential. Disclosure of peer review information is prohibited. Normally, release of information will occur only upon receipt of a valid court order.

**Article 10  
Communication**

**10.1** Mechanisms designed to provide for effective communication among the Medical Staff, Administration, and the Board include:

- 10.1.1** COS attendance of all Board meetings (without voting privileges)
- 10.1.2** CEO membership of MEC (without voting privileges)
- 10.1.3** CEO or designee attendance of all Medical Staff, Department and Committee meetings (without voting privileges)
- 10.1.4** Administrative report included as standing agenda item of all MS department and committee meetings.
- 10.1.5** Board includes two Medical Staff members (with voting privileges).
- 10.1.6** Medical Staff is actively involved in budgeting and strategic planning processes of CRMC.

Adopted by the Medical Staff on this 21st day of January, 1997.

Approved by the Board of Directors on this 27th day of January, 1998

Revised:

October 27, 1997

January 26, 1998

July 27, 1998

August 24, 1998

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November 27, 2000

May 20, 2002

October 1, 2009

November 2, 2009

October 29, 2012

December 1, 2014

December 7, 2015

November 7, 2016

October 30, 2017

January 29, 2018

July 27, 2020

October 26, 2020

November 10, 2022

October 19, 2023

November 25, 2024