## BYLAWS – TABLE OF CONTENTS

**PREAMBLE**.......................................................................................................................................................viii

**ARTICLE I DEFINITIONS**................................................................................................................................. 1

**ARTICLE II CATEGORIES OF THE MEDICAL STAFF**.......................................................................................... 1

- **ARTICLE II - PART A: ACTIVE STAFF** ................................................................................................. 1
- **ARTICLE II - PART B: PROVISIONAL STAFF**.......................................................................................... 2
- **ARTICLE II - PART C: COURTESY STAFF**.............................................................................................. 2
- **ARTICLE II - PART D: CONSULTING STAFF**............................................................................................ 3
- **ARTICLE II - PART E: AFFILIATE STAFF**.................................................................................................. 3
- **ARTICLE II - PART F: RESERVE STAFF** .................................................................................................... 4
- **ARTICLE II - PART G: EMERITUS STAFF**................................................................................................. 4
- **ARTICLE II - PART H: HONORARY STAFF**................................................................................................. 4
- **ARTICLE II - PART I: SPECIAL NEEDS STAFF**........................................................................................ 5
- **ARTICLE II - PART J: TELEMEDICINE PRIVILEGES** ............................................................................. 6

**ARTICLE III ORGANIZATION OF THE MEDICAL STAFF**........................................................................ 6

- **ARTICLE III - PART A: MEDICAL STAFF YEAR**.................................................................................... 6
- **ARTICLE III - PART B: OFFICERS OF THE MEDICAL STAFF** .............................................................. 6
  - Section 1. The President: ............................................................................................................................. 6
  - Section 2. The President-Elect: .................................................................................................................. 7
  - Section 3. Immediate Past President: ......................................................................................................... 7
  - Section 4. Election and Term of Officers: .................................................................................................... 7
  - Section 5. Removal of Medical Staff Officers: .......................................................................................... 8
  - Section 6. Vacancies in Office: ................................................................................................................... 8
- **ARTICLE III - PART C: MEETINGS OF THE MEDICAL STAFF** .............................................................. 8
  - Section 1. Annual Staff Meeting: .............................................................................................................. 9
  - Section 2. Regular Staff Meetings: ........................................................................................................... 9
  - Section 3. Special Staff Meetings: ............................................................................................................ 9
  - Section 4. Notice of Special Meetings: ...................................................................................................... 9
  - Section 5. Quorum: .................................................................................................................................... 9
  - Section 6. Agenda: .................................................................................................................................... 9
ARTICLE III - PART D: DEPARTMENT AND COMMITTEE MEETINGS

Section 1. Department Meetings:
Section 2. Committee Meetings:
Section 3. Special Department and Committee Meetings:
Section 4. Minutes:

ARTICLE III - PART E: PROVISIONS COMMON TO ALL MEETINGS

Section 1. Posting Notice of Meetings:
Section 2. Attendance Requirements:
Section 3. Rules of Order:
Section 4. Voting:

ARTICLE IV CLINICAL DEPARTMENTS

ARTICLE IV - PART A: CLINICAL DEPARTMENTS

ARTICLE IV - PART B: FUNCTIONS OF DEPARTMENTS

Section 1. Criteria for Privileges:
Section 2. Evaluation of Medical Care:

ARTICLE IV - PART C: QUALIFICATION & ELECTION OF DEPARTMENT CHAIRMAN AND REPRESENTATIVES

Section 1. Qualification:
Section 2. Election:
Section 3. Removal:

ARTICLE IV - PART D: FUNCTIONS OF DEPARTMENT CHAIRMAN AND REPRESENTATIVES (Revised 01/11)

Section 1. Responsibilities of Department Chairman:
Section 2. Representatives:

ARTICLE V COMMITTEES OF THE MEDICAL STAFF

ARTICLE V - PART A: APPOINTMENT OF CHAIRMEN AND MEMBERS

Section 1. Chairman:
Section 2. Members:

ARTICLE V - PART B: EXECUTIVE COMMITTEE

Section 1. Composition:
Section 2. Duties:
Section 3. Meetings, Reports and Recommendations: ................................................ 18

ARTICLE V - PART C: CREDENTIALS COMMITTEE .................................................... 19
Section 1. Composition: .................................................................................................. 19
Section 2. Duties: ............................................................................................................. 19
Section 3. Meetings, Reports and Recommendations: ................................................ 19

ARTICLE V - PART D: PERFORMANCE IMPROVEMENT COMMITTEES ......................... 20

ARTICLE V - PART E: MEDICAL STAFF BOARD MEMBER NOMINATING COMMITTEE ........ 20

ARTICLE V - PART F: CANCER COMMITTEE ..................................................................... 20
Section 1. Composition: .................................................................................................. 20
Section 2. Purpose and Responsibilities: ......................................................................... 21
Section 3. Meetings, Reports and Recommendations: ................................................ 21

ARTICLE V - PART G: MEDICAL STAFF ASSISTANCE COMMITTEE ......................... 21
Section 1. Composition: .................................................................................................. 21
Section 2. Purpose and Duties: ....................................................................................... 22
Section 3. Meetings, Reports and Recommendations: ................................................ 22

ARTICLE V - PART H: CREATION OF STANDING COMMITTEES .................................. 23

ARTICLE VI APPOINTMENTS TO THE MEDICAL STAFF ............................................. 23

ARTICLE VI - PART A: QUALIFICATIONS FOR APPOINTMENT .................................... 23

ARTICLE VI - PART B: CONDITIONS OF APPOINTMENT ........................................... 25
Section 1. Duration of Initial Provisional Appointment: .................................................. 25
Section 2. Rights and Duties of Appointees: .................................................................... 26
Section 3. Resignation or Reduction of Medical Staff Status: ......................................... 26
Section 4. Failure to Submit Letter of Resignation from Medical Staff: ......................... 26

ARTICLE VI - PART C: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES ...... 26
Section 1. Information: ..................................................................................................... 26
Section 2. Undertakings: ................................................................................................. 28
Section 3. Burden of Providing Information: ................................................................... 28
Section 4. Authorization to Obtain Information: .............................................................. 29
Section 5. Reappointment: .............................................................................................. 30
ARTICLE VI - PART D: DESCRIPTION OF INITIAL CLINICAL PRIVILEGES................................. 30
Section 1. Application for Initial Clinical Privileges: ................................................................. 30
Section 2. Credentialing Interview: ......................................................................................... 31
Section 3. Clinical Privileges for Dentists: ............................................................................. 31
Section 4. Clinical Privileges for Podiatrists: ......................................................................... 31
Section 5. Clinical Privileges for Other Specialties and Sub-Specialties: .............................. 33
Section 6. Physicians Under Contract with Hospital: ............................................................... 35

ARTICLE VI - PART E: PROCEDURE FOR INITIAL APPOINTMENT ................................................... 35
Section 1. Submission of Application.................................................................................... 35
Section 2. Initial Credentials Committee Procedure: .............................................................. 35
Section 3. Department Chairman Procedure: ........................................................................ 36
Section 4. Subsequent Credentials Committee Procedure: .................................................. 36
Section 5. Credentials Committee Report: ............................................................................ 37
Section 6. Subsequent Action on the Application: ................................................................. 37
Section 7. Renewal of Clinical Privileges.............................................................................. 38

ARTICLE VI - PART F: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES ......................... 38
Section 1. Temporary Clinical Privileges: ............................................................................. 38

ARTICLE VI - PART G: TEMPORARY PRIVILEGES. ............................................................. 39
Section 1. Application or Request Form ................................................................................. 39
Section 2. Level of Review for Temporary Privileges ............................................................. 39
Section 3. Granting Temporary Privileges ............................................................................. 41
Section 4. Denial or Termination .......................................................................................... 41
Section 5. General Conditions ............................................................................................. 42
Section 6. Special Requirements: ....................................................................................... 42

ARTICLE VI - PART H: EMERGENCY AND DISASTER CLINICAL PRIVILEGES ............................ 42

ARTICLE VI - PART I: MEDICAL HISTORY AND PHYSICAL EXAMINATION PRIVILEGES .......... 43

ARTICLE VI - PART J: OTHER LICENSED INDEPENDENT ALLIED HEALTH PRACTITIONERS 45
Section 1. Definition: ............................................................................................................. 45
Section 2. Categories: ........................................................................................................... 45
Section 3. Requirements for Granting Clinical Privileges: .................................................... 46
Section 4. Appointment:........................................................................................................... 46
Section 5. Clinical Privileges:.................................................................................................. 46
Section 6. Reappointment:........................................................................................................ 49
Section 7. Corrective Action or Adverse Recommendation Procedures:................................. 49
Section 8. Automatic Termination of Clinical Privileges:.......................................................... 50

ARTICLE VII ACTIONS AFFECTING MEDICAL STAFF APPOINTEES.............................................. 51

ARTICLE VII - PART A: PROCEDURE FOR APPOINTMENT ............................................................ 51
Section 1. When Application is Required: .......................................................... 51
Section 2. Factors to be Considered:............................................................................. 51
Section 3. Department Procedure:.................................................................................. 52
Section 4. Credentials Committee Procedure. ............................................................. 52
Section 5. Meeting with Affected Individual: ............................................................... 53
Section 6. Procedure Thereafter: ................................................................................. 54

ARTICLE VII - PART B: PROCEDURE FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES...... 54
Section 1. Application for Increased Clinical Privileges:............................................... 54
Section 2. Factors to be Considered:............................................................................. 54
Section 3. Evaluation. ....................................................................................................... 54

ARTICLE VII - PART C: COLLEGIATE INTERVENTION AND PROCEDURE FOR ACTIONS INVOLVING CLINICAL COMPETENCE OR BEHAVIOR OF MEDICAL STAFF APPOINTEES .............. 55
Section 1. Collegial Intervention:..................................................................................... 55
Section 2. Grounds for Action:....................................................................................... 55
Section 3. Investigative Procedure:.................................................................................. 56
Section 4. Procedure Thereafter: ................................................................................. 57

ARTICLE VII - PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES........................................ 58
Section 1. Grounds for Summary Suspension: ............................................................. 58
Section 2. Executive Committee Procedure: ............................................................... 59
Section 3. Care of Suspended Individual’s Patients:.................................................... 59

ARTICLE VII - PART E: AUTOMATIC SUSPENSION, AUTOMATIC RELINQUISHMENT, AND AUTOMATIC RESIGNATION.......................................................................................... 59
Section 1. Action by State Licensing Agency: ............................................................... 59
Section 2. Other Automatic Actions................................................................................. 59
ARTICLE VII - PART F: PROCEDURE FOR LEAVE OF ABSENCE ........................................................ 60
ARTICLE VIII HEARING AND APPEAL PROCEDURES ........................................................................... 62
ARTICLE VIII - PART A: INITIATION OF HEARING ........................................................................... 62
ARTICLE VIII - PART B: THE HEARING ............................................................................................ 62
   Section 1. Notice of Recommendation: ........................................................................................... 62
   Section 2. Ground for Hearing ......................................................................................................... 63
   Section 3. Unappealable Actions: ................................................................................................. 63
   Section 4. Notice of Hearing and Statement of Reasons: ............................................................ 64
   Section 5. List of Witnesses: .......................................................................................................... 64
   Section 6. Hearing Panel: ............................................................................................................. 64
   Section 7. Failure to Appear: .......................................................................................................... 65
   Section 8. Postponements and Extensions: .................................................................................... 65
   Section 9. Deliberations and Recommendations of the Hearing Panel: .................................... 65
   Section 10. Disposition of Hearing Panel Report: ......................................................................... 65
ARTICLE VIII - PART C: HEARING PROCEDURE .............................................................................. 65
   Section 1. Representation: ............................................................................................................. 65
   Section 2. Hearing Officer: ............................................................................................................ 66
   Section 3. Presiding Officer: ......................................................................................................... 66
   Section 4. Record of Hearing: ......................................................................................................... 66
   Section 5. Rights of Both Sides: .................................................................................................... 66
   Section 6. Admissibility of Evidence: ............................................................................................ 66
   Section 7. Official Notice: ............................................................................................................. 67
   Section 8. Basis of Decision: .......................................................................................................... 67
   Section 9. Burden of Proof: ............................................................................................................ 67
   Section 10. Attendance by Panel Members: ................................................................................... 68
   Section 11. Adjournment and Conclusion: .................................................................................... 68
ARTICLE VIII - PART D: APPEAL ........................................................................................................... 68
   Section 1. Time for Appeal: ............................................................................................................ 68
   Section 2. Grounds for Appeal: ...................................................................................................... 68
   Section 3. Time, Place and Notice: ............................................................................................... 69

Bay Medical Bylaws
(12/9/2014)
Section 4. Nature of Appellate Review: ................................................................. 69
Section 5. Final Decision of the Board: ................................................................. 69
Section 6. Further Review: .................................................................................. 69
Section 7. Right to One Appeal Only: ................................................................. 70

ARTICLE IX AMENDMENTS TO MEDICAL STAFF BYLAWS ................................................................. 70
ARTICLE X RULES, REGULATIONS AND POLICIES OF THE MEDICAL STAFF ........................................... 71
ARTICLE XI CONFLICT RESOLUTION ................................................................. 69
PREAMBLE

WHEREAS, Bay Medical Center is a private hospital organized under the laws of the State of Florida;

WHEREAS, its purpose is to serve as a general hospital providing patient care, education and research; and

WHEREAS, the medical staff is a self-governing body that is accountable to the board;

WHEREAS, the organized medical staff through its departments, committees and officers oversees the quality of patient care, treatment and services provided by practitioners privileged through the medical staff process, and is accountable to the Board for the quality and safety of medical care treatment and services in the hospital; and

WHEREAS, the board wishes to delegate to the medical staff, including the clinical departments, committees of the medical staff, and to certain officers of the staff, chairmen of those departments and members of those committees, the duty and responsibility to make recommendations to the board concerning an applicant’s appointment or reappointment to the medical staff of the hospital and the clinical privileges such applicant shall enjoy in the hospital; and

THEREFORE, to discharge these duties and responsibilities to the hospital in an orderly fashion, the physicians, podiatrists and dentists practicing in Bay Medical Center shall function and act in accordance with the following bylaws and the rules, regulations and policies that have been approved by the medical staff and the Board. The hospital management shall cooperate with and assist the appointees to the medical staff in the accomplishment of this responsibility to the hospital pursuant to these bylaws.
ARTICLE I
DEFINITIONS
The following definitions shall apply to terms used in these bylaws:

1. “Board” means the Board of Trustees of Bay Medical Center, which serves as the governing body and has the overall responsibility for the quality and safety of care and the operation of the hospital, including the Medical Staff;

2. “Chief Executive Officer (CEO)/Medical Staff Administrator” means the administrator appointed or selected by the Board, or his/her designee.

3. “Focused Professional Practice Evaluation” or “FPPE” means a process whereby the hospital evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing a requested privilege at the hospital. The FPPE process may also be used when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care. FPPE will include at least 15 cases subject to retrospective review plus any other time-limited period during which the hospital evaluates the practitioner’s professional performance as defined in the rules, regulations or policies, or by the chairman of the department or departments in which he has clinical privileges, or by the relevant committees of the Medical Staff.

4. “Executive Committee” means the Executive Committee of the Medical Staff unless specifically written “Executive Committee of the Board;”

5. “Medical staff” means all physicians, dentists and podiatrists who are granted privileges to treat patients in the hospital;

6. “Ongoing Professional Practice Evaluation” or “OPPE” means the ongoing professional practice evaluation that allows the hospital to identify professional practice trends that impact the quality of care and patient safety, as set forth in the rules, regulations and policies.

7. “Physicians” shall be interpreted to include both medical doctors ("MDs") and doctors of osteopathy ("DOs");

Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.

ARTICLE II
CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board, after recommendation by the medical staff, through the clinical department chairman, Credentials and Executive Committees and shall be to one of the following categories of the staff. All appointees to the medical staff shall meet the general qualifications for medical staff appointment as outlined in Article VI, Part A of these bylaws. All appointees shall be appointed to a specific department, but shall be eligible for privileges in other departments as applied for and recommended pursuant to the bylaws and approved by the Board.

ARTICLE II - PART A: ACTIVE STAFF

The active staff shall consist of those physicians (MD, DO), dentists (DDS, DMD), and podiatrists (DPM), whose primary practice is located in Bay County. Active members must remain within reasonable
commuting distance to the hospital sufficient to provide continuing care to their patients and respond to emergency situations. Active staff may admit patients to the hospital and exercise such privileges granted by the Board. Each appointee to the active staff shall agree to assume the functions and responsibilities of appointment to the active staff including, where appropriate, care for service patients, on-call services, as required, and emergency service care, consultation and teaching assignments. Active staff appointees shall be entitled to vote, hold office, serve on medical staff committees, and serve as chairmen of such committees. They shall be required, upon penalty as determined by the Executive Committee, to attend 50 percent of all regular medical staff meetings and respective clinical department meetings per year. Active staff must have served on the provisional staff for at least 12 consecutive months prior to becoming eligible for advancement to active staff.

ARTICLE II - PART B: PROVISIONAL STAFF

The provisional staff shall consist of physicians (MD, DO), dentists (DDS, DMD), and podiatrists (DPM), whose primary practice is located in Bay County and who will be considered for advancement to active or courtesy staff. Provisional members must remain within reasonable commuting distance to the hospital sufficient to provide continuing care to their patients and respond to emergency situations. Provisional staff may admit patients and exercise such privileges granted by the Board. Persons appointed to the provisional staff shall agree to assume the functions and responsibilities of appointment including, where appropriate, care for service patients, on-call services, as required, and emergency service care, consultation and teaching assignments. Provisional staff members shall be entitled to vote and serve on Medical Executive Committee. They shall be required to attend 50 percent of all regular medical staff meetings and respective clinical department meetings per year. Provisional staff membership shall be for a period of one year and members shall then be eligible for active or courtesy staff membership, but may request or be required to serve additional time up to a maximum of two years. Each provisional staff member will be subject to a Focused Professional Practice Evaluation process for his/her initial clinical privileges as set forth in Article VI.

ARTICLE II - PART C: COURTESY STAFF

The courtesy staff shall consist of physicians (MD, DO), dentists (DDS, DMD), and podiatrists (DPM), whose primary practice is located in Bay County within reasonable commuting distance to the hospital to provide continuing care to their patients, provide on-call services, as required, and respond to emergency situations and who do not desire appointment to the active staff or who are not eligible for appointment to the active staff because they do not intend to attend or admit or be involved in the care of more than an average of five (5) or more patients each month during each appointment year, including outpatient admissions and consultations, at the hospital, excluding admissions occurring during emergency room call for unattached patients. Courtesy staff may admit patients and exercise such privileges granted by the Board. Courtesy staff members will be obliged to participate in emergency room call at a frequency equal to one half of the call frequency of an active staff member in that respective department. An appointee to the courtesy staff shall be required to serve an initial provisional period as required for appointment to Bay Medical Bylaws

(12/9/2014)
the active staff, except when medical staff appointment changes from active staff to courtesy staff, and the appointee has previously served a provisional period. Appointment to the courtesy staff does not entitle the appointee to serve on medical staff committees, to vote or hold office, however, they may vote to elect medical staff leaders who will be compensated with medical staff dues. They are encouraged to attend staff and department meetings.

ARTICLE II - PART D: CONSULTING STAFF

The consulting staff shall consist of physicians (MD, DO), dentists (DDS, DMD), and podiatrists (DPM), whose primary practice is located in Bay County within reasonable commuting distance to the hospital sufficient to provide continuing care to their patients and respond to emergency situations, and who will be appointed for the specific purpose of providing consultation, as requested by an active, courtesy or provisional medical staff member, in the diagnosis and treatment of patients in clinical specialties not provided by existing active or courtesy staff members. Appointment to the consulting staff does not entitle the appointee to admit patients or perform procedures, to vote or to hold staff office, or to serve on medical staff committees, however, they may vote to elect medical staff leaders who will be compensated with medical staff dues. They may, but are not required to, attend department or medical staff meetings.

In the event a physician, dentist or podiatrist is appointed to the medical staff in the same specialty as provided by a consulting medical staff member, the consulting staff member must immediately voluntarily resign his/her membership and privileges or advance to active or courtesy membership status. Such resignation does not constitute grounds for a hearing under Article VIII.

ARTICLE II - PART E: AFFILIATE STAFF

The affiliate staff shall consist of physicians, dentists and podiatrists (MD, DO, DDS, DMS and DPM), who regularly refer patients to the hospital. These physicians do not practice in and may not admit patients to the hospital, but still desire to maintain medical staff appointment and to access in-network hospital services that may be required for participation in managed care organizations panel(s). The affiliate staff must meet all the basic qualification and credentialing criteria as set forth for all other categories of the Medical Staff.

The affiliate staff category is a membership only category with no clinical privileges, and limited responsibilities and prerogatives. The prerogatives shall be to:

a) Regularly refer patients to the hospital for inpatient and outpatient care;

b) Provide the hospital with the name of an appointee of the medical staff with admitting privileges who will accept all of his/her patients who present to the emergency department or require admission.

As members of the Medical Staff, affiliate staff shall be fully credentialed and shall be granted membership based on recommendation by the medical staff, with approval by the Board. As no clinical privileges are granted, affiliate staff members shall not be subject to the requirements for Focused Professional Practice

Bay Medical Bylaws
(12/9/2014)
Evaluations or Ongoing Professional Practice Evaluations. Appointment to the affiliate staff does not entitle the appointee to vote or hold office or to serve on medical staff committees. They may, but are not required to, attend department or medical staff meetings.

ARTICLE II - PART F: RESERVE STAFF

The reserve staff shall consist of physicians, dentists and podiatrists (MD, DO, DDS, DMS and DPM), of demonstrated competence qualified for medical staff appointment and privileges who wish to provide coverage for active medical staff physician in the same specialty. Reserve staff members will not be required to permanently reside in Bay County but must temporarily reside in Bay County while providing the approved coverage responsibilities. Physicians, dentists, and podiatrists who maintain a medical, dental, or podiatric practice in Bay County do not qualify for reserve staff status.

The reserve staff member may not exercise any clinical privileges unless requested by an active staff member by notification to the Medical Staff Services office. Each member of the reserve staff shall only admit patients to the physician(s) they are covering for. They shall not be granted nor can they exercise any clinical privileges not granted to the physicians they are covering for. They shall discharge the basic responsibilities of the active staff member as required in these bylaws and perform other such duties as may be required under these bylaws and rules, regulations and policies, to include assuming the on-call responsibilities of the medical staff member(s) they are covering for. If appropriate and needed, the reserve staff may be required to participate in emergency room call during periods of temporary residence in Bay County. Appointment to the reserve staff does not entitle the appointee to serve on medical staff committees, to vote or hold office. Members of the Medical Staff appointed to the reserve status prior to March 1, 2002, shall be grandfathered in under the previous definition of reserve status.

ARTICLE II - PART G: EMERITUS STAFF

Medical staff appointees who have attained the age of 75 years shall, automatically, advance at that time to the emeritus staff. Such appointees may, if they desire, participate in staff activities assigned by the chairman of their department or the president of the Medical Staff.

The Credentials Committee shall specifically evaluate the mental and physical capabilities of each emeritus staff appointee who is either admitting or caring for patients within the hospital annually on their birth month. As in the case of all persons appointed to the medical staff, such evaluation may occur at any time, if so warranted.

ARTICLE II - PART H: HONORARY STAFF

The honorary staff shall consist of medical staff appointees who have retired from active hospital practice, not necessarily residing in Bay County. Persons appointed to the honorary staff shall not be eligible to admit or attend patients, to vote at staff meetings, to hold office or to serve on standing medical staff committees, but may be appointed to special committees. They may, but are not required to attend any medical staff meetings. An honorary medical staff member who desires to change his/her status to resume Bay Medical Bylaws

(12/9/2014) 4
hospital practice will be required to reapply to the Medical Staff. Consideration will be given to waiving the application fee on an individual basis.

ARTICLE II - PART I: SPECIAL NEEDS STAFF

The special needs staff shall consist of physicians (MD, DO) of demonstrated competence qualified for staff appointment who can provide a specific clinical need which cannot be provided by the existing medical staff. A request for application under this section must be accompanied by the following: a description of the specific need the potential applicant intends to fulfill, a list of the specific clinical privileges they are requesting, documentation of adequate pre- and post-operative care for each specific clinical privilege requested, and documentation of guaranteed coverage during their absence by active medical staff member(s) of comparable skill. If the specific clinical need and other required documentation is approved by the Executive Committee of the Medical Staff after recommendation from the Credentials Committee and such recommendation is approved by the Board, the physician will be allowed to apply for special needs staff and, if appointed, will not be required to permanently reside in Bay County, but must temporarily reside in Bay County while providing the specialized services for which privileges have been granted. The scope of practice and privileges granted to special needs staff members will be limited to those determined necessary by the Credentials and Executive Committees of the Medical Staff and the Board to address the specific need.

Special needs privileges shall be granted only for a specific term, not to exceed one (1) year, during which the need is anticipated to continue. At the conclusion of the initial, and any successive term of special needs privileges, the physician may reapply for an additional term under the same procedures outlined above except that the application for determination of need and the application for privileges shall proceed together. If an application for a successive term is received, in addition to all other matters considered upon reappointment of any medical staff member, the applicant shall have the burden of producing adequate information to establish that the specific need the applicant intends to fulfill still exists, and of resolving any doubts about the anticipated continuation of such need. An application for a successive term shall be denied if the specific need no longer exists or is not reasonably anticipated to continue to exist during such successive term.

Failure of a special needs staff member to provide or cause to be provided, pre- and post-operative care and coverage as documented in the application process shall constitute grounds for disciplinary action or summary suspension of privileges pursuant to Article VII, Part C and Part D, of these bylaws. Denial of appointment to the special needs staff solely for lack of need shall not preclude an immediate application to another medical staff category. Appointment to the special needs staff does not entitle the appointee to serve on medical staff committees, to vote or hold office. If appropriate and needed, special needs staff may be required to participate in emergency room call during periods of temporary residency in Bay County.
ARTICLE II - PART J: TELEMEDICINE PRIVILEGES

Active staff member(s) must sponsor these individuals, be of the same specialty as the telemedicine physician(s), and agree to be responsible for their actions. Telemedicine physicians serve as consultants only, are not part of the consulting staff, and they cannot prescribe, treat or admit. The sponsoring active staff member(s) are ultimately responsible for the care and treatment of their patients.

Telemedicine applicants may not seek medical staff membership. They are not required to sit for the initial application interview; they do not have to meet the geographic requirements for primary residence; they are ineligible to vote, serve on committees or hold office; they have no meeting requirements. Applicants must apply for privileges and be processed in the same manner as other medical staff applicants pursuant to Article VI of the medical staff bylaws subject to the exceptions noted above.

The Executive Committee will recommend privileges of telemedicine specialties and specialists on a case-by-case basis. The scope of responsibilities of approved telemedicine specialties will be noted in the bylaws and the rules, regulations and policies, and may be mended in accordance with these bylaws after appropriate clinical department approval.

ARTICLE III
ORGANIZATION OF THE MEDICAL STAFF

ARTICLE III - PART A: MEDICAL STAFF YEAR

For the purpose of these bylaws the medical staff year commences on the 1st day of January and ends on the 31st day of December each year.

ARTICLE III - PART B: OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the president, president-elect, and immediate past president. Officers must be appointed to the active staff at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 1. The President:

The president (also referred to as the chief of staff) shall:

a) Act on behalf of the medical staff and the hospital as the chief medical staff leader, in coordination and cooperation with the chief executive officer and the Board in matters of mutual concern involving the hospital;

b) Call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;

c) Appoint committee chairmen and members, to all standing and special medical staff committees except as otherwise provided in these bylaws;
d) Serve as ex officio member of all medical staff committees other than the Executive Committee without vote, except in the case of a tie;

e) Represent the views, policies, needs and grievances of the medical staff and report on the medical activities of the staff to the Board and to the chief executive officer;

f) Provide day-to-day liaison on medical matters with the chief executive officer and the Board;

g) Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibilities of the medical staff to provide medical care;

h) Be the spokesman for the medical staff in its external professional and public relations.

Section 2.  The President-Elect:

The president-elect shall:

a) Assume all the duties and have the authority of the president in the event of the president’s temporary inability to perform due to illness, being out of the community or being unavailable for any other reason;

b) Be a member of the Executive Committee of the medical staff;

c) Automatically succeed the president (i) when the president fails to serve for any reason during his/her term of office, and (ii) at the end of the president’s term;

d) Perform such duties as are assigned to him by the president.

Should both the president and the president-elect be unavailable in an emergency, the authority and duties of the president will be temporarily assumed by the chairman of the department of medicine or the chairman of the department of surgery in that order of succession.

Section 3.  Immediate Past President:

The immediate past president shall:

a) Be a member of the Executive Committee and Joint Conference Committee;

b) Perform such additional or special duties as shall be assigned to him by the president, the Executive Committee or the Board.

Section 4.  Election and Term of Officers:

Nominating Committee – At least three months before the scheduled date of the next medical staff election, the Nominating Committee; consisting of at least five active staff appointees, two of whom shall be the president-elect and current president of the Medical Staff, and the remaining three shall be the most current past presidents of the Medical Staff available or willing to serve; shall meet, nominate and post the names of one or more candidates for president-elect of the Medical Staff. If the president-elect cannot or will not serve as president, one or more candidates for president will also be nominated.
Election by the Medical Staff – Nominations shall be presented by the Nominating Committee at the December quarterly medical staff meeting. Nominations will also be accepted from the floor. The candidate who receives a majority vote of those medical staff appointees eligible to votes and present at the meeting at the time the vote is taken shall be elected. The vote may be by written secret ballot. The election of each officer shall become effective the first day of the new medical staff year, subject to approval by the Board.

Term and President’s Option to Extend – Each officer shall serve for a minimum of one medical staff year, or until his/her successor has been elected and approved by the Board. The president of the Medical Staff shall have the option, in his/her sole discretion, to continue to serve as president for one additional medical staff year, subject to Board approval. Such option expires at the beginning of the December quarterly medical staff meeting, but the president shall inform the Nominating Committee of his/her intention to extend as soon as practicable. If the president opts to continue to serve, the remaining officers shall also continue to serve in their capacity for one additional medical staff year. In no event shall any officer serve more than two (2) consecutive medical staff years in the same position.

Section 5. Removal of Medical Staff Officers:

The Executive Committee may, by two-thirds majority vote, remove any medical staff officer for conduct detrimental to the interests of the Medical Staff, or if he is suffering from a physical or mental infirmity that renders him incapable of fulfilling the duties of his/her office, providing notice of the meeting at which such action takes place shall have been given in writing to such officer at least 10 days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in his/her own behalf before the committee prior the taking of any vote on his/her removal. Such removal will be effective when approved by the Board.

Section 6. Vacancies in Office:

If there is a vacancy in the office of the president prior to the expiration of the president’s term, the president-elect shall assume the duties and authority of the president for the remainder of the unexpired term. If there is a vacancy in any other office, the Executive Committee shall appoint another active staff appointee to serve out the remainder of the unexpired term, provided however that a president-elect so appointed shall not automatically become president. Such appointment will be effective when approved by the Board.

ARTICLE III - PART C: MEETINGS OF THE MEDICAL STAFF

The officers of the medical staff shall be the president, president-elect, and immediate past president. Officers must be appointed to the active staff at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
Section 1. Annual Staff Meeting:

The Medical Staff shall, at least 10 days before the end of the staff year, hold a meeting at which the president-elect for the ensuing year shall be elected unless the president of the Medical Staff exercised his/her option to extend in accordance with Part B, Section 4(c) of this Article.

Section 2. Regular Staff Meetings:

The Medical Staff shall meet every three (3) months, on dates set at the beginning of the year by the president, to act on any matters placed on the agenda by the president, a majority of the Executive Committee, or any five (5) active staff appointees. December regular medical staff meeting shall be designated as the annual meeting.

Section 3. Special Staff Meetings:

Special meetings of the Medical Staff may be called at any time by the president of the Medical Staff, a majority of the Executive Committee or a petition signed by no less than one-fourth of the voting staff. In the event that it is necessary for the staff to act on a question without being able to meet, the voting staff may be presented with the question by mail and their votes returned to the president of the Medical Staff by mail as determined by the Executive Committee. Such a vote shall be binding so long as the question is voted on by the majority of the staff eligible to vote.

Section 4. Notice of Special Meetings:

A written notice stating the place, day, hour and purpose of any special meeting of the Medical Staff shall be mailed to each appointee eligible to vote not less than seven days before the date of such meeting, and shall be posted in the hospital as required by these bylaws. The notice of the meeting shall be deemed delivered when sent to each medical staff member’s office, or when posted in the hospital so long as the posting occurs not less than five days prior to the date of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 5. Quorum:

The presence of one-fourth of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. This quorum must exist for any business to be conducted. Any business voted upon with less than a quorum present is invalid except that a majority of the persons eligible to vote may adjourn the meeting, without further notice, until a quorum is present.

Section 6. Agenda:

The agenda at any regular medical staff meeting shall be, at the discretion of the president:

a) Call to order and acceptance of the minutes of the last regular and of all intervening special meetings;

b) Report from the Executive Committee;
c) Old business;
d) New business;
e) Report from the chief executive officer/Board of Trustees;
f) Adjournment.

All important actions of the Executive Committee shall be included in the Executive Committee’s report to the Medical Staff at any regular or any special meeting called for this purpose.

ARTICLE III - PART D: DEPARTMENT AND COMMITTEE MEETINGS

Section 1. Department Meetings:

Members of each department shall meet as a department at least quarterly at a time set by the chairman of the department to review and evaluate the clinical work of the department and to discuss any other matters concerning the department. The agenda for the meeting and its general conduct shall be set by the chairman.

Section 2. Committee Meetings:

All committees shall meet at least quarterly, unless otherwise specified, at a time set by the chairman of the committee. The agenda for the meeting and its general conduct shall be set by the chairman.

Section 3. Special Department and Committee Meetings:

a) A special meeting of any committee or department may be called by or at the request of the chairman, by the president, or by a petition signed by not less than one-third of the members of the department or committee. Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting shall be given to each member of the committee or department not less than 24 hours before the time of such meeting or posted in the hospital as required by these bylaws.

b) In the event that it is necessary for a committee or department to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the chairman of the committee or department. Such a vote shall be binding so long as the question is voted on by a majority of the committee or department eligible to vote.

Section 4. Minutes:

Minutes of each meeting of each committee and each department shall be prepared and shall include a record of the attendance of the members, of the recommendations made and of the votes taken on each matter. The minutes shall be signed by the presiding officer and a report thereof shall be forwarded to the Executive Committee and at the same time to the chief executive officer unless otherwise specified for certain committees elsewhere in these bylaws. Each committee and each department shall maintain a permanent file of the minutes of each of its meetings.
ARTICLE III - PART E: PROVISIONS COMMON TO ALL MEETINGS

Section 1. Posting Notice of Meetings:

Notice of all meetings of the Medical Staff and regular meetings of department and committees shall be sent to the officers of all department or committee members and a calendar of meetings posted on the medical staff bulletin board at least five days in advance of such meetings. This shall be deemed to constitute actual notice to the persons concerned. The attendance of any individual at any meeting shall constitute a waiver of the individual’s notice of said meeting.

Section 2. Attendance Requirements:

a) Each active staff or provisional staff appointee shall be required to attend at least 50 percent of all regular medical staff meetings and applicable department and committee meetings in each year but is expected to attend all meetings. Any person who is compelled to be absent from any meeting shall submit to the chief of staff the reason for such absence if the individual desires to receive credit for attendance at that meeting. The failure to do so, for any person required to meet the attendance requirements, shall constitute grounds for allocation of fines as set forth in the Medical Staff Rules, regulations and policies. Meeting attendance records will be reviewed with each appointee’s reappointment application.

b) Any person appointed to the Medical Staff whose clinical work is scheduled for discussion at regular a departmental meeting shall be so notified and shall be expected to attend such meeting. If such individual is not otherwise required to attend the meeting, the chairman of the department shall give him advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, shall be given by certified mail, return receipt requested, and his/her attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.

c) The chairman of the applicable department shall notify the Executive Committee of the failure of an individual to attend any meeting with respect to which he was given notice that attendance was mandatory. Unless excused by the Executive Committee upon showing of good cause, such failure shall result in an automatic suspension of all or such portion of the individual’s admitting privileges as the Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved. In all other cases, if the individual shall make a timely request for postponement supported by an adequate showing that his/her absence shall be unavoidable, the presentation may be postponed by the chairman of his/her department or by the Executive Committee if the department chairman is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.
d) Persons appointed to the consulting and courtesy categories of the Medical Staff shall be expected to attend and participate in departmental meetings unless unavoidably prevented from doing so but shall not be required to do so as a condition of continued staff appointment.

Section 3.  Rules of Order:

All business shall be conducted by motion or resolution moved, seconded and carried by a majority of those present and entitled to vote. Rules of order may be established and amended by the chair from time to time in the interests of order and fairness but may not conflict with these bylaws. In the absence of established rules, any ruling by the chair intended to promote the orderly disposition of business shall control unless such a ruling is shown to fundamentally unfair.

Section 4.  Voting:

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote. A majority vote means more than one-half of the votes cast by persons present and entitled to vote, excluding blanks and abstentions, at a regular or properly called meeting at which a quorum is present. A two-thirds vote means at least two-thirds of the votes cast by persons present and entitled to vote, excluding blanks and abstentions, at a regular or properly called meeting at which a quorum is present. Members may not vote by proxy.

ARTICLE IV
CLINICAL DEPARTMENTS

ARTICLE IV - PART A: CLINICAL DEPARTMENTS

The following clinical departments are established. Additional departments or divisions of departments, as required from time to time, may be established by the Executive Committee after considering recommendations from the Medical Staff.

a) Medicine;
b) Surgery;
c) OB/GYN;
d) Pediatrics;
e) Pathology;
f) Radiology;
g) Emergency Medicine;
h) Hospitalist Medicine (non-voting).

Clinical departments may include divisions established by the department chair.

Bay Medical Bylaws
(12/9/2014) 12
ARTICLE IV - PART B: FUNCTIONS OF DEPARTMENTS

Section 1. Criteria for Privileges:

Each clinical department or division shall establish its own written criteria for the assignment of clinical privileges and the conduct of Ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations for new privileges. Such criteria shall be consistent with and subject to these bylaws and the rules, regulations and policies of the Medical Staff and of the Board and subject to approval by the Executive Committee and the Board. Clinical privileges shall be based upon demonstrated training and experience within the field covered by the department.

Section 2. Evaluation of Medical Care:

a) Each department or division shall conduct Ongoing Professional Practice Evaluations of department members and evaluate medical care on a prospective a retrospective basis and shall select cases for presentation at departmental or medical staff meetings that will contribute to the continuing education of the medical staff members. Such presentations should include cases involving deaths or complications, and such other cases as are believed to be important, such as those involving patients currently in the hospital with unsolved clinical problems.

b) In discharging these functions each department and division shall submit a report to the Executive Committee on a regular basis detailing its analysis of patient care. Whenever further investigation and appropriate action involving any individual member of the department is indicated, the process outlined in Article VII, Part C of these bylaws shall be followed.

c) The department of surgery or its designee shall conduct a comprehensive review to examine justification of surgery performed whether tissue was removed or not, and to evaluate the acceptability of the procedure chosen for surgery. Specific consideration shall be given to the agreement of disagreement of the pre-operative and post-operative (including pathological) diagnosis. Written reports shall be maintained reflecting the results of all evaluations performed and action taken.

d) The department of OB/GYN shall oversee and review the activities of its department members. Obstetrical review shall include quality assurance of reasonable obstetrical practice to include review of primary Cesarean sections and anesthetic complications. Any member wishing to deviate from the standard must submit a protocol for his/her anesthetic procedures that are in accord with and acceptable to the anesthesia staff. Gynecological surgery performed with correlation of pre- and post-operative diagnosis as well as pathological findings. Obstetrical and gynecology call for labor and delivery and the emergency room shall be the responsibility of the OB/GYN department as a whole. All active members shall share in the call schedule as per Medical Staff Bylaws.
ARTICLE IV - PART C: QUALIFICATION & ELECTION OF DEPARTMENT CHAIRMAN AND REPRESENTATIVES

Section 1. Qualification:

a) Each clinical department shall have a chairman who shall represent the department on the Executive Committee, and one additional representative on the Executive Committee for each 35 active staff appointees, or part thereof, in excess of 35 active staff appointees.

b) The chairman and representative of each department shall be an appointee to the active staff who is qualified by training, experience and administrative ability for the position.

c) The chairman of each medical staff department shall be certified by an appropriate specialty board, or affirmatively establish through the privilege delineation process that he or she possesses comparable competence.

Section 2. Election:

The chairman and any representative of each department shall be elected by a majority vote of the active staff appointees of the department present at the department meeting at the time the vote is taken. The election of each department chairman and representative, if any, shall become effective the first day of the new medical staff year, subject to approval by the Board. The chairman and any representative shall hold office during the medical staff year or until their respective successor has been elected and approved by the Board.

Section 3. Removal:

If a department chair or representative ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice privileges or no longer practices at the hospital or any other good cause exists; that member may be removed from the department position. Removal of a chairman or representative during his/her term of office may be initiated by a two-thirds vote of all active staff appointees in the department. This removal shall be effective when it has been approved by the Board.

ARTICLE IV - PART D: FUNCTIONS OF DEPARTMENT CHAIRMAN AND REPRESENTATIVES (Revised 01/11)

Section 1. Responsibilities of Department Chairman:

a) Accountability for all professional and administrative activities within the department, including:
   1) Plan department meetings agendas and conduct department meetings;
   2) Attend departmental quality improvement committee meetings;
   3) Represent department members on the Executive Committee;
   4) Enforce hospital and Medical Staff Bylaws, rules, regulations and policies;
   5) Implement actions taken by the Executive Committee and Board of Trustees;
   6) Communicate patient care needs of the department to hospital management;
7) Assessing and recommending to relevant hospital authority off site sources for needed patient care, treatment and services not provided by the department or the hospital;
8) Integration of the department or service into the primary function of the organization;
9) Coordination and integration of interdepartmental and intradepartmental services;
10) Development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
11) Recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services;
12) Maintenance of quality control programs, as appropriate;
13) Orientation and continuing education of all persons in the department.
14) Recommend space and other resources needed for the department.
15) Determine the qualifications and competence of department personnel who are not physicians, dentists, podiatrists or licensed independent allied health practitioners in collaboration with hospital administration.

b) Delineation of privileges within the department.
   1) Recommend criteria for clinical privileges that are relevant to the care provided within the department;
   2) Interview new applicants for department privileges and forward recommendation to Credentials Committee;
   3) Assess clinical privileges and current competency of all members applying for reappointment, to include all allied health professionals;
   4) Assist with development of credentialing criteria and review applications for expansion of clinical privileges;
   5) Review all requests for change of membership status.
   6) Recommend clinical privileges for each department member.

c) Surveillance of department members’ performance.
   1) Continuously monitor Ongoing Professional Practice Evaluations of department members, and ensure that such processes are integrated into the department members’ ongoing evaluation and periodic credentialing and re-credentialing.
   2) Continuously monitor any Focused Professional Practice Evaluations, and ensure that the results of the process are integrated into the department members’ ongoing evaluation, and periodic credentialing and re-credentialing.
   3) Provide continuous surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
   4) Review professional performance of all individuals with clinical privileges in conjunction with reappointment process;
   5) Counsel department members regarding specific performance issues and/or concerns.

d) Evaluation of quality of care provided in the department.

Bay Medical Bylaws
(12/9/2014)
1) Coordinate quality improvement activities to include full scope of care provided by all department members. Provide continuous assessment and improvement of the quality of care and services provided;
2) Assist with development of clinical indicators and screening criteria used to identify patient care issues or concerns;
3) Implement results of QI studies to improve patient care.

Section 2. Representatives:

Each department representative shall:
   a) Be a member of the Executive Committee giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding patient care in the department;
   b) Assist the chairman in implementing within the department actions taken by the Board and the Executive Committee.

ARTICLE V
COMMITTEES OF THE MEDICAL STAFF

ARTICLE V - PART A: APPOINTMENT OF CHAIRMEN AND MEMBERS

Section 1. Chairman:
   a) Appointment of all committee chairmen, unless otherwise provided for in these bylaws, will be reviewed by the Board upon receiving appointments from the president of the Medical Staff. All chairmen shall be selected from among persons appointed to the active staff.
   b) Such appointments will be confirmed by the Board at its first meeting after the end of the medical staff year, for an initial term of one year. After serving an initial term, a chairman may be reappointed for a maximum of three additional yearly terms. All appointed chairmen may be removed and vacancies filled by the president of the Medical Staff at his or her discretion, with the approval of the Executive Committee.

Section 2. Members:
   a) Members of each committee, except as otherwise provided for in these bylaws, shall be appointed yearly by the president of the Medical Staff no more than 10 days after the end of the medical staff year, with no limitation in the number of terms they may serve. All appointed members may be removed with vacancies filled by the president of the Medical Staff at his/her discretion, with the approval of the Executive Committee.
   b) The chief executive officer and the president of the Medical Staff or their respective designees shall be members, ex-officio without vote, on all committees.
ARTICLE V - PART B: EXECUTIVE COMMITTEE

Section 1. Composition:

a) The Executive Committee shall consist of the officers of the Medical Staff, the chairman and representatives, if any, of each clinical department. The majority of the voting members of the Executive Committee are licensed physician members of the active staff.

b) The president of the Medical Staff shall be the chairman of the Executive Committee.

c) The chief executive officer is an ex-officio member of the Executive Committee without vote. The chief executive officer or his/her designee shall sit with the Executive Committee and participate in its discussions, except when it meets in Executive Session or as requested by the physician members of the committee.

d) A department chairman or representative unable to attend an Executive Committee meeting shall be entitled to nominate as his/her proxy, for all business coming before the meeting, any active staff appointee who is a member of that department and has previously served as chairman or representative of that department.

Section 2. Duties:

The duties of the Executive Committee delegated by the medical staff shall be:

a) To represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these bylaws;

b) To coordinate the activities and general policies of the various departments;

c) To receive and act upon committee reports, and to make recommendations concerning them to the chief executive officer and the Board;

d) To implement rules, regulations and policies of the Medical Staff which are not the responsibility of the departments;

e) To provide liaison among Medical Staff, the chief executive officer and the Board;

f) To recommend action to the chief executive officer on matters of a medico-administrative and hospital management nature;

g) To ensure that the Medical Staff is kept abreast of The Joint Commission accreditation program and informed of the accreditation status of the hospital;

h) To take steps to ensure the enforcement of hospital and Medical Staff bylaws, rules, regulations and policies in the best interest of patient care and of the hospital on the part of all persons who hold appointment to the Medical Staff, and to make recommendations to the Board on actions described in Article VII;

Bay Medical Bylaws
(12/9/2014)
i) To recommend medical staff appointment and clinical privileges for physicians, dentists, podiatrists and any other licensed independent allied health practitioners;

j) To address situations involving questions of the clinical competence, patient care and treatment or case management of any persons who hold appointments to the Medical Staff, including initiation of a Focused Professional Practice Evaluation or investigation;

k) To fulfill medical staff accountability to the Board for the quality and safety of medical care, treatment and services rendered to patients in the hospital;

l) To review bylaws, rules, regulations and policies of the Medical Staff at least once a year and propose any amendments thereto as may be necessary or desirable in accordance with Article IX and X, as applicable;

m) To recommend to the Board the medical staff structure and the process used to review credentials and delineate privileges;

n) To determine minimum continuing education requirements for appointees to the staff;

o) To make recommendations to the Board on reports of medical staff committees, departments and other assigned medical staff groups.

In any instance where a member of the Executive Committee has a conflict of interest in any matter involving another medical staff appointee which comes before the Executive Committee, or in any instance where a member of the Executive Committee brought the complaint against that appointee, that member shall not participate in the voting on the matter, and shall absent himself from the meeting during that time, although he may be asked and answer any questions concerning the matter before leaving.

The chairman of the Executive Committee, his/her representative and such members of his/her committee as may be necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.

Section 3. Meetings, Reports and Recommendations:

The Executive Committee shall meet at least once each month or more often if necessary to transact pending business. The president-elect or his/her designee will maintain reports of all meetings, which reports shall include the minutes of the various committees and departments of the staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the chief executive officer routinely as prepared and important actions of the Executive Committee shall be reported to the staff as part of the Executive Committee’s report at each quarterly staff meeting. Recommendations of the Executive Committee shall be transmitted to the chief executive officer and through him to the Board as the committee deems appropriate.
ARTICLE V - PART C: CREDENTIALS COMMITTEE

Section 1.  Composition:

The Credentials Committee shall consist of the five most recent past presidents who are still appointees to the active staff. The chairman shall be that member of the committee with the greatest seniority on the committee. Service on this committee shall be considered as the primary medical staff obligation of each member of the committee and other medical staff duties shall not interfere. The president of the Medical Staff shall appoint up to five additional members of the committee for terms of one year if at any time the continued work ability of the committee is threatened by the inability or unwillingness of the past presidents to serve.

Section 2.  Duties:

The duties of the Credentials Committee shall be:

a) To review the credentials of all applicants, to make such investigations of and interview applicants as may be necessary, and to make recommendations for appointment and in consultation with department chairmen delineate clinical privileges in compliance with these bylaws;

b) To make a report to the Executive Committee and Board of Trustees on each applicant for medical staff appointment and clinical privileges, including specific consideration of the recommendation from the departments in which such applicant requests privileges;

c) To review all information regarding the competence of staff members (including the results of FPPE and OPPE evaluations) and to make recommendations to the Executive Committee and Board of Trustees for the granting, reduction or withdrawal of privileges, reappointments and assignment of practitioners to the various departments or services as provided in Article VI of these bylaws.

In any instance where a member of the Credentials Committee has a conflict of interest in any matter involving an applicant or appointee to the staff which comes before the Credentials Committee, that member shall not participate in the discussion or voting on the matter and shall absent himself from the meeting during that time, although he may be asked and answer any questions concerning the matter before leaving.

The chairman of the Credentials Committee, the chairman’s representative, or such members of the committee as are deemed necessary shall be available to meet with the Executive Committee and the Board on all recommendations that the Credentials Committee may make.

Section 3.  Meetings, Reports and Recommendations:

The Credentials Committee shall meet as often as necessary to accomplish its duties and shall maintain a permanent record if its proceedings and actions shall report its recommendations to the Executive Committee and Board of Trustees.
ARTICLE V - PART D: PERFORMANCE IMPROVEMENT COMMITTEES

The Medical Staff shall participate in performance improvement activities designed to measure, assess and improve organization-wide performance and patient safety. Where a clinical process is the primary responsibility of physicians, the Medical Staff shall assume a leadership role. Such processes include but are not limited to medical assessment and treatment of patients; use of medications and nutritional supplements; performance of operative, invasive, and non-invasive procedures to include the use of anesthesia; use of blood and blood components; appropriateness of clinical practice patterns; surveillance, prevention, and control of infections, significant departures from established patterns of clinical practice; and patient safety reports and data. The Medical Staff shall be involved in other activities related to the measurement of outcomes and assessment of performance including oversight in the process of analyzing and improving patient satisfaction. Results of such activities and actions taken to improve organization performance shall be communicated to the appropriate medical staff members. When the findings of such performance measurement activities are relevant to an individual with clinical privileges, the Medical Staff shall conduct peer review and/or periodic evaluations in accordance with standards on renewing or revising clinical privileges.

ARTICLE V - PART E: MEDICAL STAFF BOARD MEMBER NOMINATING COMMITTEE

A multi-disciplinary Nominating Committee shall make nominations for the medical staff appointees to the Board of Trustees at Bay Medical Center.

This Nominating Committee shall be composed of two active staff representatives each from the departments of medicine and surgery, one representative each from the departments of pediatrics, OB/GYN, radiology, emergency medicine, and pathology. The Nominating Committee appointments shall be selected by a majority vote of the respective clinical departments during the year of each Board appointment expiration or as needed upon resignation of a medical staff Board appointee.

The Nominating Committee shall meet in a timely fashion prior to the medical staff Board appointment expiration and select their nominee(s) from the active medical staff members of Bay Medical Center. The Nominating Committee shall submit the name of their nominee(s) for appointment to the Board of Trustees to the Medical Staff at large for a vote. Additional nominations from the floor will be accepted.

ARTICLE V - PART F: CANCER COMMITTEE

Section 1. Composition:

The Cancer Committee shall be a medical staff standing committee at Bay Medical Center. This Committee will pursue approved Cancer Program compliance by following all criteria as stated in the Cancer Program Standards published by the Commission on Cancer. The chairman and physician members of the Cancer Committee shall be appointed on an annual basis by the Cancer Committee chairman and the liaison physician and approved by the president of the Medical Staff.
a) Physicians representing the various disciplines involved in the care of the cancer patient including, but not limited to, radiation oncology, medical oncology, pathology, surgery, internal medicine, gynecology, and diagnostic radiology;

b) Additional representatives from other clinical departments/services directly involved in patient care as may be deemed appropriate.

Others serving on the committee include the cancer liaison physician and the cancer registrar, as well as representatives from administration, nursing, social services and quality administration.

Section 2. Purpose and Responsibilities:

The Cancer Committee shall:

a) Assure compliance with the requirements of the American College of Surgeons for an approved cancer center;

b) Provide leadership in the cancer program of the hospital and stimulate a spirit of unity, purpose, and responsibility on the part of the staff in providing a high quality cancer patient care;

c) Provide professional direction to the cancer management system, review data collected by the system, and refer to the Medical Staff such portions of these data as deemed pertinent;

d) Coordinate multi-disciplinary, hospital-wide and case-oriented tumor conferences as well as other continuing education programs for the Medical Staff.

Section 3. Meetings, Reports and Recommendations:

The Cancer Committee shall meet as often as needed, but at least quarterly, and shall provide an annual report to the Medical Staff and hospital administration outlining the activities of the cancer program. Minutes shall be maintained in the Cancer Center with copies forwarded to the medical staff office. A summary of the Cancer Committee meetings shall be included in the bi-monthly Patient Care Committee reports presented at medical staff clinical department and Executive Committee meetings.

ARTICLE V - PART G: MEDICAL STAFF ASSISTANCE COMMITTEE

Section 1. Composition:

The Medical Staff Assistance Committee shall be comprised of not less than three (3) members of the active Medical Staff, a majority of which (including the chairperson), shall be physicians. Each member shall serve a term of three (3) years, which shall be staggered as deemed appropriate by the Executive Committee to achieve continuity. As far as possible, the members of this committee shall not serve as active participants on any peer review or quality improvement committees including Credentials Committee.

Bay Medical Bylaws
(12/9/2014)
Section 2. Purpose and Duties:

Purpose: This committee shall develop and implement a process separate from the medical staff disciplinary function to evaluate, assist, and rehabilitate any potentially impaired staff member including, but not limited to, physical or mental impairments and alcohol or drug dependency. The committee shall have no disciplinary powers. The goals of the committee should be to help potentially impaired staff members retain or regain optimal professional functioning, consistent with patient protection and safety. But, if at any time, the committee determines that a staff member is unable to safely perform his/her privileges, the committee shall forward the matter to the medical staff leadership for consideration of appropriate corrective action. This committee should also provide for:

a) Staff education about general physician health matters;

b) Training on identification and prevention of physical, psychiatric, or emotional illness; and

c) Facilitation of confidential diagnosis, treatment, and rehabilitation or medical staff members who suffer from a potentially impairing condition.

Duties: The committee shall have the following duties and responsibilities:

a) Define the process for education of the Medical Staff and other organization staff about illness and impairment recognition issues specific to physicians and medical staff members;

b) Develop procedures for confidential self-referrals by staff members and anonymous referrals by other staff members or organization staff;

c) Maintain the confidentiality of staff members seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;

d) Evaluate the credibility of a referral, complaint, allegation, or concern;

e) Referral of affected staff members to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern as needed;

f) Monitoring of the affected staff member and the safety of patients until the rehabilitation or any disciplinary process is complete; and

g) Immediate reporting to the president of the Medical Staff, the chairman of a clinical department, the chief executive officer or in his/her absence a designee, or the chairman of the Board and the Executive Committee in instances in which a staff member is providing or presents an imminent risk of providing unsafe treatment.

Section 3. Meetings, Reports and Recommendations:

The committee shall meet as often as necessary. It shall not be required to maintain records of its proceedings, but shall confidentially report on its activities on a routine basis to the Executive Committee.
ARTICLE V - PART H: CREATION OF STANDING COMMITTEES

The Executive Committee of the Medical Staff may, by resolution, and upon approval of the Board, without amendment of these bylaws, establish a committee, i.e., Psychiatric, I.C.U., Human Experimentation Committees, etc., to perform one or more staff functions. In the same manner the Executive Committee may by resolution dissolve or rearrange committee structure, duties or composition as needed, to better perform the medical staff functions. Any function required to be performed by these bylaws which are not assigned to a standing or special committee shall be performed by the Executive Committee.

ARTICLE V - PART I: SPECIAL COMMITTEES

Special committees shall be created and their members and chairman shall be appointed by the president of the Medical Staff as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

DUE PROCESS PROCEDURES

ARTICLE VI

APPOINTMENTS TO THE MEDICAL STAFF

ARTICLE VI - PART A: QUALIFICATIONS FOR APPOINTMENT

a) Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent physicians (MD, DO), dentists (DDS, DMD) and podiatrists (DPM) who meet the qualifications, standards and requirements set forth in these bylaws. All individuals practicing medicine, dentistry and podiatry in this hospital, unless excepted by specific provisions of these bylaws, must first have been appointed to the Medical Staff.

b) Only physicians, dentists and podiatrists who meet the following qualifications shall be eligible for medical staff membership:

1) Licensure: Members shall be currently licensed to practice in this state;
2) Residency: Members shall maintain a primary residence and reside in Bay County within reasonable commuting distance to the hospital sufficient to provide continuing care to their patients, and respond to emergency situations, unless otherwise provided for in these bylaws for the medical staff category under application;
3) Training: Members shall have successfully completed an appropriate residency program approved by the Accreditation Council for Graduate Medical Education or American Osteopathic Association, and which has a major affiliation with a U.S. or Canadian medical school or operated by a U.S. Department of Defense, consisting of at least two consecutive years of supervised patient care at the same training program; are currently certified by or are an eligible candidate for certification by the appropriate specialty board approved by the American Board of Medical Specialties or equivalent board of the American Osteopathic
Association. If two (2) consecutive years of supervised patient care at the same training program have not been completed, certification by the appropriate specialty board approved by the American Board of Medical Specialties or equivalent board of American Osteopathic Association; or Royal College of Physicians and Surgeons of Canada or Royal College of Family Physicians of Canada.

4) **Board Certification**: Members shall be currently certified by or are eligible candidates for certification by the appropriate specialty board approved by the American Board of Medicine Specialties or equivalent board of the American Osteopathic Association or the American Board of Physician Specialties. Graduates of Canadian medical schools or residency trained applicants shall be certified or board eligible in an American specialty board or an equivalent Canadian specialty board when the American boards do not allow reciprocity. Such Canadian equivalent specialty board must be certified by the Royal College of Physicians and Surgeons of Canada or the Royal College of Family Physicians of Canada. Applicants with a Canadian Board certification shall comply with all other requirements for medical staff membership regardless of the Canadian specialty board requirements.

All persons who apply for and accept medical staff membership and privileges acknowledge that staff membership and privileges are conditioned upon their obtaining board certification within the maximum time allowable by the appropriate specialty board. If no time limit exists, the medical staff member shall obtain board certification within seven years from the initial date of appointment to the Medical Staff, regardless of leaves of absence or resignations from the Medical Staff. Board eligible medical staff members shall submit a report to the Credentials Committee on their progress towards board certification at each biennial reappointment period. Failure of a staff member to become board certified within the allotted time (subject to the Grandfathering provision below) shall constitute complete and sufficient grounds for automatic revocation of clinical privileges and staff membership pursuant to Article VII, Part C of the Medical Staff Bylaws. Revocation of clinical privileges and staff membership for failure to obtain board certification pursuant to this section does not entitle the individual to any of the procedural rights provided under these bylaws with respect to hearings or appeals.

Applications from former medical staff members do not reset the period to obtain board certification; membership eligibility is predicated upon the date of such applicant’s initial appointment to the Medical Staff. Applications from former members whose privileges were revoked for failure to obtain board certification will not be accepted until the applicant can document appropriate board certification.

**Grandfathering**: Notwithstanding the above, certain medical staff members are subject to different board certification requirements based on the medical staff’s board certification requirements at the time of the member’s initial application. Medical staff members who initially applied for medical staff membership:
I. Prior to January 1, 1996 are exempt from the board certification requirements in this sub-section, but are highly encouraged to become certified;

II. On or between January 1, 1998 and December 31, 2009 shall become board certified by the appropriate board within the maximum time allowed by such board. Members within this time frame are highly encouraged to obtain board certification within seven years of initial appointment and shall submit a report to the Credentials Committee on their progress towards board certification at each biennial reappointment period.

5) Who have no felony convictions substantially related to the practice of medicine; (a detailed explanation of any other felony or misdemeanor convictions must be provided with the applicant’s application);

6) Can demonstrate the ability to communicate in English both in writing and orally by achieving a satisfactory score on the test administered by the Education Commission of Foreign Medical Graduates as applicable; and

7) Can document their background, experience, training and demonstrated clinical competence, their adherence to the ethics of their profession, their good reputation and character and their ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them in the hospital will receive quality care and that the hospital and its Medical Staff will be able to operate in an orderly manner, shall be qualified to apply for appointment to the Medical Staff. The word “character” is intended to include the applicant’s overall health status, i.e., ability to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of medical staff appointment.

8) An applicant seeking privileges in podiatry must be a graduate of an approved school of podiatry and must have completed formal recognized training required for certification by the National Board of Podiatric Examiners.

c) No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that:

   1) He/she is licensed to practice any profession in this or any other state;
   2) He/she is a member of any particular professional organization;
   3) He/she had in the past, or currently has, medical staff appointment or privileges in another hospital.

d) No individual shall be denied appointment on the basis of sex, race, creed, color or national origin.

ARTICLE VI - PART B: CONDITIONS OF APPOINTMENT

Section 1. Duration of Initial Provisional Appointment:

All initial appointments to the Medical Staff regardless of the category of the staff to which the appointment is made and all initial clinical privileges shall be provisional for a period of 12 months from Bay Medical Bylaws

(12/9/2014)
the date of the appointment or longer if recommended by the Credentials Committee. During the term of this provisional appointment, the person receiving this provisional appointment shall be subject to a Focused Professional Practice Evaluation for at least fifteen (15) cases subject to retrospective review, plus any additional time-limited period during which practitioner’s professional performance is evaluated by the chairman of the department or departments in which he has clinical privileges, and by the relevant committees of the Medical Staff and hospital as to his/her clinical competence and as to his/her general behavior and conduct in the hospital. Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner if warranted based on the results of the Focused Professional Practice Evaluation. Appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment set forth in Article VII, Part A, Section 2 of these bylaws. An appointee to the Medical Staff who does not activate membership and privileges in the hospital within 90 days of appointment shall be considered automatically voluntarily resigned from the Medical Staff.

Section 2. Rights and Duties of Appointees:

Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board and shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require.

Section 3. Resignation or Reduction of Medical Staff Status:

Medical staff appointees who wish to reduce their staff status must provide a written 90-day notice of the effective date to the Executive Committee unless there is an emergent reason this is not possible. Medical staff appointees who wish to resign from the Medical Staff must provide a written 30-day notice of the effective date to the Executive Committee unless there is an emergent reason this is not possible.

Section 4. Failure to Submit Letter of Resignation from Medical Staff:

Any medical staff member who abdicates his/her medical practice without formal notification to the hospital, i.e., letter of resignation, request for leave of absence, etc., will (after a period of 90 day or more absence) automatically relinquish her/her medical staff membership and clinical privileges.

ARTICLE VI - PART C: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

Section 1. Information:

Applications for initial appointment or reappointment to the Medical Staff shall be in writing, and shall be submitted on forms prescribed by the Medical Staff. These forms shall be obtained from the chief executive officer or his/her designee. The application shall require detailed information concerning the applicant’s professional qualifications including:

a) The names of at least three physicians, dentists, podiatrists or other practitioners, as appropriate, in addition to internship, residency and fellowship training directors, who have had recent extensive experience in observing and working with the applicant and who can provide adequate

Bay Medical Bylaws
(12/9/2014)
references pertaining to the applicant’s relevant training and/or experience, current professional competence, ability to handle complex cases, skill in performing invasive procedures, health status, and character. Only applicants rated “Good to Excellent” on the preponderance of peer and training director references will be considered for approval; a satisfactory explanation must be given for any reference rated less than “Good;”

b) Information as to the applicant’s voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at any other hospital or health care facility;

c) Information as to any previously successful or currently pending challenges to any licensure or registrations held by the applicant, or the voluntary or involuntary relinquishment of such licensure or registration, including DEA certificate. The submitted application shall include copies of all medical licenses; DEA certificate, narcotics registrations; medical, podiatric or dental school diploma; and certificates from all post graduate training programs completed;

d) A certificate of insurance evidencing professional liability coverage in the amounts approved by the Board and a consent to the release of information from his/her present and past malpractice insurance carriers, and a record of all present and past malpractice experiences, with or without insurance and a report of any final judgments or settlements involving the applicant;

e) A request for the specific clinical privileges desired by the applicant to include:

1) A list of the clinical privileges held at their most recent hospital affiliation or residency; and

2) A copy of their interventional procedure log from their residency program and/or a list of the types of surgical procedures performed or medical cases managed over the past two years as signed by their residency director or chairman of department. Applicants who have not practiced in their specialty for a minimum of two years preceding the application must also submit a detailed explanation of their interim activity and a statement of current competence from the chairman of an appropriate ACGME or AOA-approved residency program affiliated with a U.S. or Canadian medical school or the U.S. Department of Defense;

f) Information on the applicant’s ability to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of medical staff appointment;

g) Information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance;

h) Information on the citizenship and visa status of the applicant;

i) Picture identification issued by a state or federal agency (e.g., driver’s license or passport);

j) And such other information as the Board may require.

The hospital shall verify information about the applicant’s licensure, special training, experience, and current competence provided by the applicant with information from the primary source(s) whenever Bay Medical Bylaws

(12/9/2014)
feasible. Action on an individual’s application for appointment or for initial clinical privileges is withheld until such information is made available and verified.

Section 2. Undertakings:

Every application for staff appointment shall be signed by the applicant and shall contain:

a) The applicant’s specific acknowledgment of his/her obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the hospital for whom he had responsibility.

b) His/her agreement to abide by all such bylaws and policies of the hospital, including all such bylaws, rules, regulations and policies of the Medical Staff as shall be in force from time to time during the time he is appointed to the Medical Staff;

c) His/her agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him by the Board and the Medical Staff;

d) A statement that the applicant has received and read a copy of such bylaws, rules, regulations and policies of the Medical Staff as are in force at the time of his/her application and that he has agreed to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he is granted appointment to the Medical Staff or clinical privileges;

e) A statement of his/her willingness to appear for personal interviews in regard to his/her application;

f) A statement that the applicant will:

1) Refrain from fee splitting or other inducements relating to patient referral;

2) Refrain from delegating responsibility for diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

3) Refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

4) Agree to practice within the limitations and scope of his/her approved clinical privileges;

5) Seek consultation whenever necessary; and

6) Abide by generally recognized ethical principles applicable to his/her profession.

g) A statement that the applicant acknowledges that medical staff membership and privileges are conditioned upon his/her obtaining board certification by the appropriate board within time limits outlined in Article VI, Part A.

Section 3. Burden of Providing Information:

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and of resolving any doubts about such
qualifications. He shall have the burden of providing evidence that all the statements made and information given on the application are factual and true.

Section 4. Authorization to Obtain Information:

The following statements, which shall be included on the application form and which form a part of these bylaws, are express conditions applicable to any medical staff applicant, any appointee to the Medical Staff and to all others having or seeking clinical privileges in the hospital. By applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

a) Immunity: To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, and extends absolute immunity to the hospital, its authorized representatives and any third parties as defined in subsection c) below, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:

1) Applications for appointment or clinical privileges, including temporary privileges;
2) Evaluations concerning reappointment or changes in clinical privileges;
3) Proceedings for suspension or reduction of clinical privileges for revocation of medical staff appointment, or any other disciplinary sanction;
4) Summary suspension;
5) Hearings and appellate reviews;
6) Medical care evaluations, including Ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations;
7) Utilization reviews;
8) Other activities relating to the quality of patient care or professional conduct;
9) Matters or inquiries concerning the applicant’s or appointee’s professional qualifications, credentials, clinical competence, character, ethics, behavior, and ability to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of medical staff appointment; or
10) Any other matter that might directly or indirectly have an effect on the individual’s competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

The foregoing acts, communications and documents shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

b) Authorization to Obtain Information: The applicant or appointee specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant’s or appointee’s professional qualifications, credentials, clinical competence, character, ethics, behavior, and ability to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of medical staff membership or
any other matter reasonably having a bearing on the satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be material to such questions. The applicant or appointee also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.

c) Definitions:

1) As used in this section, the term “hospital and its authorized representatives” means the hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon the application or conduct in the hospital; the members of its Board and their appointed representatives; the chief executive officer or his/her designees; other hospital employees; consultants to the hospital; the hospital attorney and his/her partners, associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the applicant’s or appointee’s credentials, or acting upon his/her application or conduct in the hospital.

2) As used in this section, the term “third parties” means all individuals including: appointees to the hospital’s Medical Staff; appointees to the medical staffs of other hospitals; other physicians, dentists, podiatrists, health practitioners and nurses; or other organizations, associations, partnerships and corporations, or government agencies, whether hospitals, health care facilities or not; from whom information has been requested by the hospital or its authorized representatives.

Section 5. Reappointment:

Completed applications for reappointment will be submitted by the physician, dentist or podiatrist at least sixty (60) days before expiration of the then-current appointment. Reappointment applications will follow the process for initial appointment under Article V.

ARTICLE VI - PART D: DESCRIPTION OF INITIAL CLINICAL PRIVILEGES

Section 1. Application for Initial Clinical Privileges:

Medical staff appointment or reappointment shall not confer any clinical privileges or right to practice in the hospital. Each individual who has been given an appointment to the Medical Staff of the hospital shall be entitled to exercise only those clinical privileges specifically recommended to the Executive Committee and approved by the Board. The clinical privileges recommended to the Board shall be based upon the applicant’s education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The applicant shall have the burden of establishing his/her qualification for competence to exercise the clinical privileges requested. Recommendations of the clinical department in which privileges
are sought shall be forwarded to the Credentials Committee and thereafter as part of the initial application for staff appointment.

Section 2. Credentialing Interview:

Each applicant for medical staff membership and privileges may be required to undergo a credentialing interview prior to official approval of clinical privileges. The department chairman and applicable members of the department to which the applicant is applying shall be invited to attend the interview for the purpose of reviewing the applicant’s training and clinical competence for the privileges being requested and making a recommendation to the Credentials and Executive Committees. The members of the Credentials Committee and president of the Medical Staff shall also be invited to attend all credentialing interviews. Prospective associates of the applicant may attend the interview by invitation only. Spouses and relatives of the applicant shall not be in attendance at the credentialing interview.

Section 3. Clinical Privileges for Dentists:

The scope and extent of surgical procedures that a dentist may perform in the hospital shall be delineated and recommended in the same manner as other clinical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the chairman of the department of surgery. A medical history and physical examination of the patient shall be made and recorded by a physician (M.D. or D.O.) who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization. Dentists are responsible for the part of their patients’ history and physical examination as it relates to dentistry. Qualified oral and maxillofacial surgeons may perform the medical history and physical examination, if granted such privileges, in order to assess the medical, surgical and anesthetic risk of the proposed operative procedure.

Section 4. Clinical Privileges for Podiatrists:

Podiatrists requesting clinical privileges shall have successfully completed an American Podiatry Association hospital residency program and become board certified by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics, the American Council of Certified Podiatric Physicians and Surgeons, or be an active candidate for certification. Board certification requirements must be met as outlined in Article VI, Part A of these Medical Staff Bylaws, rules, regulations and policies. The scope and extent of surgical procedures that a podiatrist may perform in this hospital shall be delineated and recommended to the Board in the same manner as clinical privileges for physicians and dentists. Surgical procedures performed by the podiatrists shall be under the overall supervision of the chairman of the department of surgery. Prior to the surgical procedure, a history and physical examination of the patient shall have taken place and been recorded in the medical record by a podiatrist credentialed to perform history and physical exams or by a physician (MD or DO) who holds an appointment to the Medical Staff. The podiatrist shall be responsible for the podiatric care of the patient as well as all appropriate elements of the patient’s record. The podiatrist may write orders within the scope of his/her
license and consistent with the Medical Staff Rules, regulations and policies and in compliance with the hospital and Medical Staff Bylaws.
Section 5. Clinical Privileges for Other Specialties and Sub-Specialties:

Physicians in each clinical department agree to complete appropriate documentation for medical history and physical exams in accordance with state law and hospital policy.

a) Department of Medicine

Each physician requesting specialty or subspecialty privileges in the department of medicine including, but not limited to, cardiology, gastroenterology, neurology, nephrology, hematology/oncology, pulmonary medicine, dermatology, psychiatry, general/family practice, physical medicine and rehabilitation, radiation oncology, etc., must present evidence of being an active candidate for certification or board certified as outlined in Article IV, Part A, Section 4 of the Medical Staff Bylaws, and shall have successfully completed the appropriate residency program approved by the ACGME or AOA consisting of at least two consecutive years of supervised patient care at the same training program. Additionally, any physician requesting privileges in general/family practice to include obstetrics or pediatrics must present evidence of satisfactory training and experience in obstetrics or pediatrics consistent with the guidelines adopted by the American Board of Family Practice and either the American College of Obstetrics and Gynecology or the American Board of Pediatrics, as appropriate, or the equivalent boards relating to the AOA. Candidates for privileges in the department of medicine may undergo an in-person interview with the chief of medicine or his/her designee and at least two members of the department prior to the granting of any privileges.

b) Department of Surgery

Each physician requesting privileges in surgery or anesthesiology must present evidence of being an active candidate for certification or board certified by the appropriate specialty board as outlined in Article IV, Part A, Section 4 of the Medical Staff Bylaws, and shall have successfully completed the appropriate residency program approved by the ACGME or the AOA consisting of at least two consecutive years of supervised patient care at the same training program. Candidates for privileges in the department of surgery (including dentists and podiatrists) may undergo an in-person interview with the chief of surgery or his/her designee and at least two members of the department prior to the granting of any privileges.

c) Department of Pediatrics

Each physician requesting privileges in the specialty of pediatrics must present evidence of being an active candidate for certification or board certified by the appropriate specialty board as outlined in Article IV, Part A, Section 4 of the Medical Staff Bylaws, and shall have successfully completed the appropriate residency program approved by the ACGME or the AOA consisting of at least two consecutive years of supervised patient care at the same training program. Candidates for privileges in the department of pediatrics may undergo an in-person interview with the chief of
pediatrics or his/her designee and at least one member of the department prior to the granting of any privileges.

d) Department of Obstetrics/Gynecology

Each physician requesting privileges in the specialty of obstetrics and gynecology (OB/GYN) must present evidence of being an active candidate for certification or board certified by the appropriate specialty board as outlined in Article IV, Part A, Section 4 of the Medical Staff Bylaws, and shall have successfully completed the appropriate residency program approved by the ACGME or the AOA consisting of at least two consecutive years of supervised patient care at the same training program. Candidates for privileges in the department of OB/GYN may undergo an in-person interview with the chief of OB/GYN or his/her designee prior to the granting of any privileges.

e) Department of Pathology

Each physician requesting privileges in pathology must present evidence of being an active candidate for certification or board certified by the appropriate specialty board as outlined in Article IV, Part A, Section 4 of the Medical Staff Bylaws, and shall have successfully completed the appropriate residency program approved by the ACGME or the AOA consisting of at least two consecutive years of supervised patient care at the same training program. Candidates for privileges in the department of pathology may undergo an in-person interview with the chief of pathology or at least one member of the department prior to the granting of any privileges.

f) Department of Radiology

Each physician requesting privileges in diagnostic or therapeutic radiology must present evidence of being an active candidate for certification or board certified by the American Board of Radiology or equivalent board of the American Osteopathic Association (AOA), and shall have successfully completed the appropriate residency program approved by the ACGME or the AOA consisting of at least two consecutive years of supervised patient care at the same training program. Candidates for privileges in the department of radiology may undergo an in-person interview with the chief of radiology or at least two members of the department prior to the granting of any privileges.

g) Department of Emergency Medicine

Each physician requesting full-time privileges in emergency medicine must present evidence of being an active candidate for certification or board certified as outlined in Article IV, Part A, Section 4 of the Medical Staff Bylaws, in the specialties of emergency medicine, family practice or internal medicine and shall have successfully completed the appropriate residency program approved by the ACGME or the AOA consisting of at least two consecutive years of supervised patient care at the same training program. Candidates for privileges in the department of emergency medicine may undergo an in-person interview with the chief of emergency medicine or at least two members of the department prior to the granting of any privileges.

h) Department of Hospitalist Medicine
Each physician requesting membership in department of hospitalist medicine must present evidence of being an active candidate for certification or board certified by the appropriate specialty board as outlined in Article IV, Part A, Section 4 of the Medical Staff Bylaws, in the specialties of internal medicine or family medicine and shall have successfully completed the appropriate residency program approved by the ACGME or the AOA consisting of at least two consecutive years of supervised patient care at the same training program. Candidates for privileges in the department of hospitalist medicine may undergo an in-person interview with the chief of hospitalist medicine or his/her designee prior to the granting of any privileges.

Section 6. Physicians Under Contract with Hospital:

a) The Board shall have the authority from time to time to enter into contracts or employment relationships with physicians for the performance of certain services including those in medico-administrative positions. All physicians functioning pursuant to such contracts or employment relationships shall obtain and maintain staff appointment and clinical privileges, in accordance with the provisions of these bylaws.

b) If a question concerning clinical competence arises that may affect the physician’s staff appointment or clinical privileges during the term of the contract, that question shall be processed in the same manner as would pertain to any other medical staff appointee. If a modification of privileges or appointment resulting from such action is sufficient to prevent the physician from performing his/her contractual duties, the contract shall automatically terminate.

ARTICLE VI - PART E: PROCEDURE FOR INITIAL APPOINTMENT

Section 1. Submission of Application

a) The application for medical staff appointment shall be submitted by the applicant to the chief executive officer or his/her designee. It must be accompanied by payment of such processing fees as may be established by the Medical Staff and Board from time to time. After collecting references and other information or materials deemed pertinent, the chief executive officer or his/her designee shall determine the application to be complete and transmit the application and all supporting materials to the Credentials Committee for evaluation.

b) If an application is incomplete 90 days from submission, the applicant shall be contacted. If the application remains incomplete because of the failure of the applicant to proceed following an additional 30-day period, the application shall be deemed withdrawn and the application processing fee forfeited.

Section 2. Initial Credentials Committee Procedure:

Upon receipt of the completed application for appointment, the Credentials Committee or their designee shall:

Bay Medical Bylaws
(12/9/2014) 35
a) Inform the chairman of each department in which the applicant seeks clinical privileges of the pending application, furnish a copy of the application to each chairman concerned and request recommendations.

b) Before approving a category of privileges or granting requested privileges, the Credentials Committee, with input from administration and the department chairman, will consider whether the hospital has sufficient resources (e.g., space, equipment, staffing, and financial resources) to support the requested privilege are available at the hospital, or will be available within a specified time frame.

Section 3. Department Chairman Procedure:

The chairman of each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with recommendations from the department for approving or disapproving the application and for delineating the applicant’s clinical privileges. These recommendations shall be made a part of the Credentials Committee’s report. As part of the process of making this recommendation, the department chairman and the department have the right to meet with the applicant to discuss any aspect of his/her application, qualifications, and/or requested clinical privileges.

Section 4. Subsequent Credentials Committee Procedure:

a) The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee including an appraisal from the chairman of the clinical department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the staff category and clinical privileges requested by him.

b) As part of this process the Credentials Committee may require a physical, mental or biomedical examination of the applicant by a physician or physicians satisfactory to the committee and shall require that the results be made available for the committee’s consideration.

c) After considering the recommendations of the clinical departments concerned, the Credentials Committee shall, if the recommendation for appointment is favorable, recommend to the Executive Committee provisional department assignment and provisional clinical privileges.

d) As part of the process of makings its recommendation, the Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of his/her application, his/her qualifications and his/her clinical privileges.

Applicants who are being considered for an adverse recommendation by the Credentials Committee will be informed of general tenor of committee and be offered an opportunity to meet with and provide any additional information to the committee prior to their official recommendation.

If a hearing is held, the hearing officer will be required to establish reasonable discovery rules so neither the medical staff representative(s) at the hearing nor the person who requested the hearing are surprised Bay Medical Bylaws
(12/9/2014) 36
at the new evidence offered at the hearing. The medical staff representative(s) shall also make the hearing panel aware that the person requesting the hearing was offered the opportunity to submit all information to the Credentials Committee prior to their final recommendation.

The hearing officer will inform the hearing panel of their responsibility to determine the merits of the issue based on evidence presented at the hearing (qualifications for appointment, reappointment or additional privileges or propriety of discipline).

Section 5. Credentials Committee Report:

a) Not later than 90 days from its receipt of the completed application, the Credentials Committee shall make a written report and recommendation on the applicant to the Executive Committee.

b) If the recommendation of the Credentials Committee is delayed longer than 90 days, the chairman of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee explaining the delay.

c) The Credentials Committee shall transmit to the Executive Committee its recommendation that the applicant be appointed to the Medical Staff, that the application be deferred for further consideration, or that the application be rejected for medical staff appointment. The chairman of the Credentials Committee or his/her designee shall be available to the Executive Committee or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

Section 6. Subsequent Action on the Application:

a) When the recommendation of the Credentials Committee is favorable to the applicant and approved by the Executive Committee, the chief executive officer or designee, shall promptly forward it, together with all supporting documentation, to the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges. The applicant will be informed of the Board’s action within seven days.

b) When the recommendation of the Credentials Committee is to defer the application for further consideration, it must be followed up within 30 days by a subsequent recommendation to the Executive Committee for appointment to the Medical Staff with specified clinical privileges, or for rejection of the application for staff appointment.

c) When either:

1) The recommendation of the Credentials Committee is adverse to the applicant in respect to either appointment to the staff or clinical privileges requested and the said recommendation is approved by the Executive Committee, or

2) The recommendation of the Credentials Committee is favorable to the applicant but said recommendation is not approved by the Executive Committee, the Executive Committee’s
recommendation shall be forwarded to the chief executive officer who shall promptly notify the applicant by certified mail, return receipt requested.

The chief executive officer shall then hold the application until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII. At the time the applicant has deemed to have waived his/her right to a hearing, the chief executive officer shall forward the recommendation of the Executive Committee, together with all supporting documentation to the Board. If the applicant requests a hearing, the recommendation of the hearing panel shall be made to the Executive Committee.

d) After the Executive Committee has considered the report and recommendation of the hearing panel and the hearing record, its final recommendation, together with all supporting documentation, shall be promptly forwarded to the Board of Trustees. The chief executive officer or designee shall also promptly notify the applicant, by certified mail with return receipt requested, of the Executive Committee’s final recommendation.

e) The Board of Trustees shall act on the recommendations of the Executive Committee at their next regular meeting or within 45 days, whichever occurs sooner. If an appellate review is requested due to a negative recommendation from the Executive Committee, due process procedures as outlined in Article VIII shall apply. Upon final Board action, practitioners will be notified within seven (7) days of decision.

Section 7. Renewal of Clinical Privileges

Applications for renewal of clinical privileges will be submitted by the physician, dentist or podiatrist with the application for reappointment at least sixty (60) days before expiration of the then-current appointment. Applications for new or renewal of clinical privileges will follow the process for initial privileges under Article VI. The department chair will submit the results of any complaints, investigations, Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations to the Credentials Committee for review.

ARTICLE VI - PART F: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Section 1. Temporary Clinical Privileges:

Under certain circumstances, clinical privileges may be requested and granted for a limited period of time (“Temporary Privileges”). There are two circumstances in which Temporary Privileges may be granted. Temporary Privileges may be granted:

1) To fulfill an important patient care, treatment, and service need which may include but is not limited to:
(i) Providing care, treatment, and services for one or more specific patients, with the specific duration of the Temporary Privileges limited to the period of the patient’s admission to the hospital; or

(ii) At the request of a medical staff member, for specific clinical privileges to meet a need for patient care, treatment and services, for a defined period of up to 120 days.

(2) When a new applicant with a completed application that raises no concerns is awaiting review and approval of the Executive Committee and the Board. Temporary Privileges for new applicants shall automatically expire in 120 days.

ARTICLE VI - PART G: TEMPORARY PRIVILEGES.

Section 1. Application or Request Form

(1) Physicians, dentists or podiatrists seeking Temporary Privileges to care for specific patients must complete an application in the format prescribed by the Medical Staff.

(2) Physicians, dentists or podiatrists seeking Temporary Privileges during the pendency of a completed application must have submitted a completed application for Medical Staff membership and privileges and all required supplemental documentation.

Section 2. Level of Review for Temporary Privileges

The Medical Staff must review the qualifications of any who requests Temporary Privileges and assure that the available information supports the granting of the Temporary Privileges. The nature of the Medical Staff review of an application for Temporary Privileges may vary, depending upon the reason for Temporary Privileges and the specific clinical privileges the physician, dentist or podiatrist requests.

Two levels of review for Temporary Privileges apply:

(1) Level One: Level One is the minimum Medical Staff review that must be completed for each physician, dentist or podiatrist who has requested Temporary Privileges to fulfill an important patient care, treatment and service need. It consists of the following steps:

(a) Application. Completion of an application with any supplemental documentation requested for an important patient care, treatment and service need. The physician, dentist or podiatrist must document the important patient care, treatment and service need and provide information regarding his or her qualifications and also certify his or her agreement to abide by the Medical Staff Bylaws and the rules, regulations and policies.

(b) Verification of Licensure. The physician, dentist or podiatrist must submit a copy of his or her license. Medical Staff Services will verify that the license is valid and unrestricted with the Florida Board of Medicine.
(c) **Verification of Professional Liability Insurance.** The physician, dentist or podiatrist must identify his or her insurer and provide a certificate of coverage.

(d) **Querying the National Practitioner Data Bank.** Medical Staff Services will query the National Practitioner Data Bank, and the persons authorized to grant Temporary Privileges will review the results.

(e) **Obtain Copy of Federal DEA.** If the physician, dentist or podiatrist seeks Temporary Privileges that includes prescribing controlled substances, Medical Staff Services will obtain a copy of his or her federal DEA certificate.

(f) **Verification of Relevant Education/Training.** Primary source verification of education/training will be obtained.

(g) **Verification of Current Competence.** One reference from a professional peer in the same specialty and at least one reference from a primary hospital affiliation will be obtained.

(h) **Querying the Office of Inspector General Exclusion List.** Medical Staff Services will query the Office of the Inspector General Exclusion List and the persons authorized to grant Temporary Privileges will review the results.

(i) **Verification of Current Competence** as evidenced by a minimum of one reference from a professional peer who has personal knowledge of and is directly familiar with the applicant’s professional competency.

(2) **Level Two:** A Level Two review must be completed by the Medical Staff for Temporary Privileges for pendency of a completed application. The same review will conducted in accordance with Article VI; provided, however, the Credentials Committee may delegate its duties under Article VI, Part E to one or more Credentials Committee members. It consists of the following steps:

(a) **Application:** Submission and processing of a completed application.

(b) **Verification of Licensure.** The physician, dentist or podiatrist must submit a copy of his or her license. Medical Staff Services will verify that the license is valid and unrestricted with the Florida Board of Medicine.

(c) **Verification of Professional Liability Insurance.** The physician, dentist or podiatrist must identify his or her insurer and provide a certificate of coverage.

(d) **Querying the National Practitioner Data Bank.** Medical Staff Services will query the National Practitioner Data Bank and the persons authorized to grant Temporary Privileges will review the results.
(e) **Obtain Copy of Federal DEA.** If the physician, dentist or podiatrist seeks Privileges, which include prescribing controlled substances, Medical Staff Services will obtain a copy of his or her federal DEA certificate.

(f) **Verify Hospital Affiliation.** Medical Staff Services must communicate with the equivalent of Medical Staff Services of one or more hospitals where the applicant primarily practices or has recently practiced.

(g) **Querying the Office of Inspector General Exclusion List.** Medical Staff Services will query the Office of the Inspector General Exclusion List and the persons authorized to grant Temporary Privileges will review the results.

(h) **Verification of relevant education and training.**

(i) **Verification of current competence** as evidenced by a minimum of one reference from a professional peer who has personal knowledge of and is directly familiar with the applicant’s professional competency.

(j) **Verification of no current or previously successful challenge to licensure or registration.**

(k) **Verification of no current or previous involuntary termination of staff membership at another organization.**

(l) **Verification of no current or previous involuntary limitation, reduction, denial, or loss of clinical privileges.**

**Section 3. Granting Temporary Privileges**

(1) Temporary Privileges may be granted by the Chief Executive Officer or his or her designee, on the recommendation of the chief of staff or his/her designee, who may include the Department Chair where the privileges will be exercised, or either’s designee.

(2) Temporary Privileges shall automatically terminate the earlier of 120 days, at the end of the designated period or upon conclusion of the need for patient services, unless earlier terminated.

**Section 4. Denial or Termination**

(1) There is no right to Temporary Privileges. Accordingly, Temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting physician’s, dentist’s or podiatrist’s qualifications, ability, and judgment to exercise the clinical privileges requested in accordance with the Medical Staff Bylaws and the rules, regulations and policies, and only after the appropriate level of review under this Article VI.
(2) Temporary Privileges may be automatically terminated or summarily suspended in accordance with the Bylaws.

(3) The granting of any Temporary Privileges is a courtesy on the part of the hospital. The denial, termination, suspension or restriction affecting such privileges shall not entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

(4) Whenever Temporary Privileges are terminated, suspended, revoked, or expire, the appropriate department chairman or, in his/her absence, the president of the Medical Staff shall assign to a medical staff appointee responsibility for the care of such terminated individual’s patients until they are discharged from the hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(5) Temporary Privileges shall be automatically terminated at such time as the Credentials Committee recommends unfavorably with respect to the applicant’s appointment to the staff or at the Credentials Committee’s discretion shall be modified to conform to the recommendation of the Credentials Committee that the applicant be granted different permanent privileges from the Temporary Privileges.

Section 5. General Conditions

(1) Physicians, dentists or podiatrists granted Temporary Privileges shall be subject to Focused Professional Practice Evaluations, Ongoing Professional Practice Evaluations and other quality improvement review.

(2) Physicians, dentists or podiatrists requesting or receiving Temporary Privileges shall be bound by the Medical Staff Bylaws and rules, regulations and policies.

(3) Licensed Independent Allied Health Practitioners may request and be granted Temporary Privileges in accordance with this Article VI.

Section 6. Special Requirements:

Special requirements of supervision and reporting may be imposed by the department chairman concerned on any individual granted Temporary Privileges. Temporary Privileges shall be immediately terminated by the chief executive officer or his/her designee upon notice of any failure by the individual to comply with such special conditions. The imposition of special requirements or termination of Temporary Privileges does not entitle the individual to any of the procedural rights provided under these Bylaws with respect to hearings or appeals.

ARTICLE VI - PART H: EMERGENCY AND DISASTER CLINICAL PRIVILEGES

Section 1. Emergency Privileges
In the event of an emergency for an individual patient, any medical staff member with clinical privileges shall be permitted to provide any type of patient care, treatment and services necessary as a life-saving measure or to prevent serious harm, regardless of his/her medical staff status or clinical privileges, so long as the care, treatment or services are within the scope of the member’s license.

The medical staff member may request Temporary Privileges to continue care of the patient if appropriate, but in no event will emergency patient care, treatment or services be delayed pending consideration or approval of Temporary Privileges.

**Section 2. Disaster Privileges**

In the event of an emergency as described in the Emergency Management Plan, disaster privileges may be granted to licensed independent practitioners who are not currently privileged at the hospital on an emergency basis. The Incident Commander, the Medical Care Director or other first-tier incident command center staff may initiate the Emergency Management Plan and disaster privileges may be granted to ensure that essential patient care can be rendered.

The president of the Medical Staff and the chief executive officer (or their designees) will work as a team to coordinate the granting of disaster privileges following those procedures outlined in Article XV of the Rules and Regulations. No licensed independent practitioner is entitled to fair hearings and/or appeals at the hospital in connection with the termination of disaster privileges.

**ARTICLE VI - PART I: MEDICAL HISTORY AND PHYSICAL EXAMINATION PRIVILEGES**

Privileges to perform all or part of a patient’s medical history and physical examination include the following requirements:
Section 1. The medical history and physical examination must be completed and documented by a physician, a dentist, a podiatrist or other licensed independent allied health practitioner in accordance with state law, these Medical Staff Bylaws and the rules, regulations and policies. More than one member or practitioner may participate in the performance, documentation or authentication of the history and physical for a single patient as provided in the Bylaws.

Section 2. A medical history and physical examination will be completed and documented for each patient (including 23 hour observation) no more than 30 days before or 24 hours after admission or outpatient registration, but prior to surgery or a procedure requiring anesthesia services, whichever comes first.

Section 3. When the medical history and examination is completed within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient’s condition, is completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral maxillofacial surgeon, a podiatrist or other licensed independent allied health practitioner in accordance with state law, the Bylaws, and the rules, regulations and policies.

Section 4. The history and physical should include at least the following information:

   a) Chief complaint
   b) Details of present illness
   c) Relevant past social and family histories
   d) Inventory by body system
   e) Summary of psychosocial need
   f) Relevant physical examination
   g) Conclusion or impression drawn from history and physical
   h) Diagnosis or diagnostic impression
   i) Goals of treatment and treatment plan

The admitting physician will be notified by applicable hospital personnel within two working days after failure to record the history and physical. If not recorded within the next working day, the medical record will be considered delinquent.

In an emergency when there is no time to record the complete history and physical examination, a note on the preoperative diagnosis is recorded before surgery. The history and physical exam for non-inpatients must minimally include patient demographics, chief complaint or diagnosis, pertinent past medical/social history, allergies, current medications, and review of systems with current physical assessment relevant to the diagnosis/procedure.
ARTICLE VI - PART J: OTHER LICENSED INDEPENDENT ALLIED HEALTH PRACTITIONERS

Section 1. Definition:

The Medical Staff recognizes that certain health care practitioners are qualified to provide certain degrees of direct patient care within the hospital complex and by reason of exercising their skills in accordance with their license, can provide services which the Medical Staff may determine to be beneficial to the care of its patients. Therefore, although these health care professionals are not members of the Medical Staff, they may be granted clinical privileges to provide patient care in the manner and in accordance with the requirements set forth in this section.

Section 2. Categories:

Health care practitioners will be divided into two categories, category I – Licensed independent Allied Health practitioner, and category II – Directly supervised Allied Health practitioners.

a) Licensed Independent Allied Health Practitioners – This category includes self-employed or agency-employed specialists who are graduates of approved training programs, such as:
   1) Clinical psychologist
   2) Audiologist
   3) Speech therapist and speech pathologist
   4) Other such specialists, not provided by the hospital

b) Directly Supervised Allied Health Practitioners – This category includes individuals who are employed by or under the direct supervision of individual members of the Medical Staff. The clinical privileges for a category II Allied Health practitioner must be within the same specialty and clinical privileges as the supervising physician. For the purposes of this article, “direct supervision” means a relationship where the medical staff member directs and authorizes the specific course of medical treatment, but need not be present when the procedures are performed, provided always that the category II practitioner is able to immediately contact their supervising medical staff member when needed.

This category will be further subdivided into:

1) Subdivision A:
   i. Certified physician assistants
   ii. Certified nurse anesthetists
   iii. Clinical pharmacists
   iv. Advance Registered Nurse Practitioners

2) Subdivision B:
   i. Physician trained assistants – Physician trained assistants include those who have received university graduate training and are certified, and others who have had
specialized but less formal training, i.e., certified nurse operating room (CNOR), RNs and LPNs, certified operating room technicians (CORT), operating room technicians (ORT), orthopedic technicians, dental assistants, military corpsmen, etc.

ii. Trainees – Individuals working under a training protocol approved by the Credentials Committee and administered and supervised by a supervising physician on the active Medical Staff.

Section 3. Requirements for Granting Clinical Privileges:

Requirements for granting clinical privileges shall follow the procedures outlined in the Medical Staff Bylaws with the additional requirements that:

a) Applicants in category I must be sponsored by a member of the Medical Staff and present an application and request for clinical privileges to the Credentials Committee. The applicant assumes responsibility for his/her submission. These specialists will be under the general supervision of the practitioner requesting their services.

b) An applicant in category II must be employed by or under the direct supervision of an individual member of the Medical Staff. The staff member will assume full responsibility for the application, the applicant’s performance and the applicant’s conduct at the hospital. The staff member will present a written statement to the Credentials Committee that he/she assumes this responsibility. Any physicians who will be supervising the Allied Health practitioner, in the absence of the primary supervising and sponsoring physician, must also sign the application form.

c) All applicants must be licensed by the State of Florida, where applicable.

d) A detailed and complete listing of the proposed duties and responsibilities and requested clinical privileges of the requesting applicant must be submitted prior to consideration.

Section 4. Appointment:

Applications for Allied Health practitioners in categories I and II will be reviewed by the Credentials Committee and the appropriate clinical department chairman. The appropriate department chairman will make a recommendation on the requested clinical privileges to the Credentials Committee. The Credentials Committee will make its recommendations to the Executive Committee. The Executive Committee may approve, reject, or defer the granting of clinical privileges. Appeal of an adverse recommendation may be made by a category I applicant or by the physician staff member in category II, which will be carried out in accordance with the procedures in Section 7 of this Article.

Section 5. Clinical Privileges:

The clinical privileges granted will be specifically delineated and continually under supervision. The following are general guidelines in this regard:

a) Certified Physician Assistants
1) Physician assistants must be graduates of a recognized accredited physician assistant program, be licensed by the state, and be in the employ of a member of the Medical Staff.
2) Physician assistants do not have admitting privileges and may not admit patients to the hospital.
3) Physician assistants may perform the official history and physical examination on admissions by their supervising physician to the floor and may perform discharge summaries. These are to be countersigned within 24 hours by the supervising physician. The physician must see the patient within 12 hours of admission to the floor.
4) Physician assistants may perform the official history and physical examination on patients admitted by their supervising physician through the hospital’s emergency room, however, not when the patient requires admission to the ICUs.
5) Physician assistants may write daily progress notes, to be countersigned within 24 hours by their supervising physician. The supervising physician is still expected to make daily rounds on their patients as well.
6) Physician assistants may write orders but they must be countersigned by their supervising physician within 24 hours. The order should indicate “voice order written for (supervising physician).”
7) Physician assistants may assist in surgery and perform other functions that their Board allows and for which they have been specifically credentialed, with the exception of the above exclusions.
8) Physician assistants may participate in consultations by performing an initial screening and triage of patients for their supervising physician. Physicians shall complete and be responsible for the consultation report. All signed by the supervising physician within 24 hours. Physician assistants may dictate or write the initial screening/triage reports as long as the report clearly indicates that it was “dictated/drafted “ by (PA) for (supervising physician).
9) Physician assistants may not cancel any order written by a physician.

b) Certified Nurse Anesthetists
1) Nurse anesthetists must be graduates of a recognized and accredited nurse anesthetist program, be certified by the Board of Nursing, licensed by the state, and be employed by or under the supervision of individual members of the Medical Staff.
2) Nurse anesthetists do not have admitting privileges and may not admit patients to the hospital.
3) Nurse anesthetists may not perform the official history and physical examination.
4) Nurse anesthetists may write pre-op evaluation notes and post-op progress notes, to be countersigned within 24 hours by their attending anesthesiologist.
5) Nurse anesthetists may deliver anesthesia, order drugs and order lab work under the supervision of their attending anesthesiologist.
6) Nurse anesthetists may participate in the management of the patient while in the post-operative recovery area. This will include the ICUs under the supervision of their attending anesthesiologist.

7) Nurse anesthetists may participate in cardiopulmonary resuscitation under the supervision of the anesthesiologist.

c) Other Advanced Registered Nurse Practitioners

1) Any registered nurse desiring clinical privileges as an advanced registered nurse practitioner must be certified by their particular specialty Board, licensed by the state, and in the employ or under the supervision of individual members of the Medical Staff.

2) A formal protocol requesting specific clinical privileges must accompany each application.

3) ARNPs do not have admitting privileges and may not admit patients to the hospital, except that specifically credentialed certified nurse midwives may admit patients for normal labor and deliveries.

4) ARNPs may perform the official history and physical examination following admissions to the floor by their supervising physician and may perform discharge summaries. These are to be countersigned within 24 hours by the supervising physician. The physician must see the patient within 12 hours of admission.

5) ARNPs may perform the official history and physical examinations on patients admitted by their supervising physician through the hospital’s emergency room, however, not when the patient requires admission to the ICUs.

6) ARNPs may write daily progress notes, to be countersigned within 24 hours by their supervising physician. The supervising physician is still expected to make daily rounds on their patients as well.

7) ARNPs may write orders but they must be countersigned by their supervising physician within 24 hours. The order should indicate “voice order written for (supervising physician).”

8) ARNPs may assist in surgery and perform other functions that their licensing board allows and for which they have been specifically credentialed, with the exception of the above exclusions.

9) ARNPs may participate in consultations by performing an initial screening and triage of patients for their supervising physician. Physicians shall complete and be responsible for the consultation report. All screening/triage consultation reports performed by an ARNP must be countersigned by the supervising physician within 24 hours. ARNPs may dictate or write the initial screening/triage report as long as the report clearly indicates that it was “dictated/drafted” by (ARNP) for (supervising physician).

10) ARNPs may not cancel any order written by a physician.

d) Clinical Pharmacists

1) Any clinical pharmacist desiring clinical privileges must be licensed by the state, and in the employ or under the supervision of individual members of the Medical Staff.
2) Clinical pharmacists do not have admitting privileges and may not admit patients to the hospital.

3) Clinical pharmacists may provide pharmacokinetic consultations as requested by a medical staff physician.

e) Physician Trained Assistants

1) Physician trained assistants do not have admitting privileges and may not admit patients to the hospital.

2) Physician trained assistants may not perform history and physical examinations, write progress notes, or dictate discharge summaries.

3) Physician trained assistants may not order lab work or drugs.

4) Physician trained assistants may assist in surgery, providing they have received adequate on the job training verified by a letter from their employing physician.

5) Physician trained assistants who are previously inexperienced in surgery in the operating room setting will be required to undergo in-service training, per the supervisor of the operating room, prior to being allowed to assist in surgery.

6) Physician trained assistants are to be under the direct supervision of their attending physician or individual members of the Medical Staff.

Section 6. Reappointment:

All Allied Health practitioners will be reviewed for reappointment every two years. They shall complete an application and request for renewal of clinical privileges. When possible, an evaluation shall be obtained from the manager or supervisor of the clinical department where the Allied Health professional practices the majority of the time in the hospital. The Credentials Committee will review the results of any Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation. Peer recommendations and attestation of continuing education compliance shall be submitted with the reappointment application. The application shall be endorsed by the supervising or sponsoring physician and approved by the applicable department chief.

Section 7. Corrective Action or Adverse Recommendation Procedures:

Nothing contained in the Medical Staff Bylaws or the rules, regulations and policies shall be interpreted to entitle an Allied Health care practitioner to any of the hearing and appeal procedural rights set forth in Article VII of the Medical Staff Bylaws. However, a health care practitioner shall have the right to challenge any action that would constitute grounds for a hearing under Article VIII, Part B, and Section 2 of the bylaws by filing a written grievance with the Executive Committee within 15 days of such action. Upon receipt of such grievance, the Executive Committee or its designee shall conduct an investigation that shall, at a minimum, interview the health care practitioner to discuss the grievance, unless such interview is waived by the health care practitioner. Any such interview shall not constitute a “hearing” as established by Article VII of the bylaws and shall not be conducted according to the procedural rules applicable to such hearings. At the interview, the health care practitioner shall be informed of the general nature and invited
to discuss, explain or justify the grievance. The health care practitioner may present information relevant to the grievance at the interview. A record of the interview shall be made. The Executive Committee shall make a decision based on the interview and all other information available to it. Such decision is final when approved by the Board.

Section 8. Automatic Termination of Clinical Privileges:

A health care practitioner’s clinical privileges shall automatically terminate, without review pursuant to Section 7 of the Article or any other section of the bylaws or the rules, regulations and policies, in the event:

a) The health care practitioner’s certification or license expires, is revoked, or is suspended.

b) The supervising medical staff member of a directly supervised Allied Health practitioner (category I)
   1) Terminates his or her medical staff membership, whether such termination is voluntary or involuntary;
   2) No longer agrees to act as the supervising member for any reason.

If the Allied Health practitioner becomes employed or sponsored by another medical staff member within 30 days, he or she will not be required to reapply but must submit the necessary paperwork to transfer to another supervising physician.

Section 10. Evaluation.

Any new clinical privileges granted by the Board will be subject to a Focused Professional Practice Evaluation of at least fifteen (15) cases subject to retrospective review plus any other time-limited period during which the hospital evaluates the practitioner’s professional performance.
DUE PROCESS PROCEDURES

ARTICLE VII
ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

ARTICLE VII - PART A: PROCEDURE FOR APPOINTMENT

Section 1. When Application is Required:

a) Any person currently appointed to the Medical Staff who at the time of processing of reappointments to the Medical Staff wishes to be considered for a change in his/her medical staff category or a change in his/her clinical privileges, or who does not desire reappointment, shall so indicate on the appropriate form submitted to the chief executive officer within a reasonable period of time but not less than 30 days prior to the expiration of his/her current appointment. All persons currently appointed to the Medical Staff who do not indicate otherwise shall be considered for reappointment to the same category of the staff with the same clinical privileges they then hold. Reappointments to the Medical Staff shall be for a period of no more than two years from their initial appointment or previous reappointment date.

b) Each current appointee who wishes to be reappointed shall be responsible for reviewing and completing the reappointment application form and stating any material changes in the information given there, particularly with regard to any professional competence or disciplinary action taken or pending against him in another hospital or health care facility and any change in status, as stated in Article VI, any voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital; any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration, any changes in his/her state license to practice medicine, podiatry, or dentistry and shall, upon request, submit proof of current state licenses and registrations. He or she may also be required to submit any reasonable evidence of current ability to perform privileges requested.

Section 2. Factors to be Considered:

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in staff category, where applicable, shall be based upon:

a) Such appointee’s professional ethics, professional performance, current clinical competence and clinical judgment in the treatment of patients and current ability to perform the privileges requested, including the results of Ongoing Professional Practice Evaluations and any Focused Professional Practice Evaluations;

b) Attendance at medical staff meetings and participation in staff affairs;
c) Compliance with the hospital bylaws and policies, and the Medical Staff Bylaws and Rules, regulations and policies;

d) Behavior and cooperation with hospital personnel;

e) Use of the hospital’s facilities for his/her patients, his/her cooperation and relations with other practitioners, and his/her general attitude toward patients, the hospital and the public;

f) Ability to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of medical staff appointment;

g) His/her involvement in any professional liability action with report of any final judgments or settlements;

h) His/her satisfactory completion of such continuing education requirements as may be imposed by law, this hospital, the medical licensure authority, or applicable accreditation agencies;

i) Receipt of satisfactory peer recommendations in support of the applicant’s reappointment to the Medical Staff and renewal of clinical privileges;

j) Confirmation of health status such that no problem exists that could affect his or her ability to perform the privileges requested.

Section 3. Department Procedure:

a) Prior to the end of the current appointment period, the chief executive officer or designee shall send to the department chairman the applications of those appointees desiring reappointment including those who wish either a change in staff category or a change in clinical privileges.

b) The chairman of each department shall transmit to the Credentials Committee the completed applications of individuals recommended for reappointment in the same medical staff category with the same clinical privileges they then hold. In addition, the chairman shall submit individual recommendations and the reasons therefore for any changes recommended in staff category, in clinical privileges, or for non-reappointment both for those who applied for changes and those who did not.

c) Recommendations for increase or decrease of clinical privileges by the department chairman shall be based upon relevant recent training and upon observation of patient care provided, review of records of patients treated in this or other hospitals and review of all other records of the Medical Staff which evaluate the appointee’s participation in the delivery of medical care, including Ongoing Professional Practice Evaluations and any Focused Professional Practice Evaluations.

Section 4. Credentials Committee Procedure.

a) The Credentials Committee, after receiving recommendations from the chairman of each department, shall review all pertinent information available including all information provided from other committees of the Medical Staff and from hospital management for the purpose of
determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing reappointment period.

The Credentials and/or Executive Committees may require that a person currently seeking reappointment submit any reasonable evidence of current ability to perform clinical privileges to include a physical or mental examination by a physician or physicians satisfactory to the committee either as part of the reappointment process or during the appointment year to aid it in determining whether clinical privileges should be granted or continued and make results available for the committee’s consideration. Failure of the person seeking reappointment to provide such evidence or procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute an automatic suspension of all medical staff and clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

b) The Credentials Committee shall prepare a list of persons currently holding appointment recommended for reappointment with and without change in staff category and clinical privileges. This list shall be considered an application to the hospital by each person on the list for reappointment to the Medical Staff and for clinical privileges for the ensuing two years. Recommendations for non-reappointment and for changes in category or privileges, with supporting data and reasons attached, shall be handled individually.

c) The Credentials Committee shall transmit its report and recommendations to the Executive Committee in time for the Board to consider reappointments. Where non-reappointment, non-promotion of an eligible current appointee, or a further limitation in clinical privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report. This report shall not be transmitted to the Board until the affected staff appointee has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII. The chairman of the Credentials Committee or his/her designee shall be available to the Executive Committee, the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation. Upon final Board action, practitioners will be notified within seven (7) days of the decision.

Section 5. Meeting with Affected Individual:

If, during the processing of a particular individual’s reappointment, it becomes apparent to the Credentials Committee or its chairman that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the chairman of the Credentials Committee shall notify the individual of the general tenor of the possible recommendation and ask him if he desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain
or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in these bylaws with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate as part of its report to the Executive Committee whether such a meeting occurred.

Section 6. Procedure Thereafter:

Any recommendation by the Executive Committee denying reappointment, denying a requested change in staff category or clinical privileges or recommending reduction of existing clinical privileges shall entitle the affected individual to the procedural rights provided in Article VIII. The chief executive officer shall then promptly notify the individual of the recommendation by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has been exercised, or has been deemed to have waived his/her right to a hearing as provided in Article VIII, after which the Board shall be given the committee’s final recommendation and shall act on it.

ARTICLE VII - PART B: PROCEDURE FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

Section 1. Application for Increased Clinical Privileges:

Whenever, during the term of his/her reappointment to the Medical Staff, an individual desires to increase his/her clinical privileges, he shall apply in writing to the appropriate clinical department chairman and the Credentials Committee. The application shall state in detail the specific additional clinical privileges desired and the applicant’s relevant training and experience which justify increased privileges. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as part of the reappointment application if the request is made at that time.

Section 2. Factors to be Considered:

Recommendations for an increase in clinical privileges made to the Board shall be based upon relevant recent training, observation of patient care provided, sufficient review of the records of patients treated in this or other hospitals, sufficient space, equipment, staffing, financial resources, and review of all records and information from applicable departments of the Medical Staff which evaluate the individual’s participation in the delivery of medical care that justify increased privileges. This recommendation for increased privileges may carry with it such requirements for supervision or consultation for such a period of time as are thought necessary.

Section 3. Evaluation.

Any increased clinical privileges granted by the Board will be subject to a Focused Professional Practice Evaluation for at least fifteen (15) patients or procedures, or such period of time defined by the applicable rules, regulations and policies.

Bay Medical Bylaws
(12/9/2014) 54
ARTICLE VII - PART C: COLLEGIAL INTERVENTION AND PROCEDURE FOR ACTIONS INVOLVING CLINICAL COMPETENCE OR BEHAVIOR OF MEDICAL STAFF APPOINTEES

Section 1. Collegial Intervention:

a) The Medical Staff may use collegial intervention to resolve issues unless serious in nature.

b) All collegial intervention efforts are part of the hospital’s performance improvement and professional peer review activities.

c) Collegial efforts involve reviewing and following up on questions raised about the clinical practice and/or professional conduct of members and pursuing counseling, education, and related steps, including the following:

(1) advising colleagues of applicable policies/procedures, such as policies/procedures regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(2) evaluating with the member complaints and concerns regarding the member’s care and/or behavior and advising and counseling the member about same;

(3) proctoring, monitoring, and consultation (the types which do not restrict a member’s privileges);

(4) letters of guidance, counseling, warning or reprimand; and

(5) requiring continuing medical education.

d) The appropriate Medical Staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in a member’s confidential file; documentation, however, is strongly encouraged. If documentation is included in a member’s file, the member will have an opportunity to review it and respond in writing. The response shall be maintained in that member’s file along with the original documentation.

e) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

f) Medical Staff leaders may also handle these matters using other provisions of these Bylaws and/or applicable policies.

Section 2. Grounds for Action:

Whenever, on the basis of information and belief, the president of the Medical Staff, the chairman of a clinical department, the chairman or a majority of any medical staff committee, the chairman of the board or the chief executive officer has cause to question, with respect to an individual holding a current medical staff appointment:

a) Clinical competence;
b) Care or treatment of a patient or patients or his/her management of a case;

c) Known or suspected violation of the bylaws or policies of the hospital, or the bylaws, rules and regulations of the Medical Staff relating to professional activity;

d) Compliance with the ethics of his/her profession or the bylaws and policies of the hospital or bylaws, rules and regulations of the Medical Staff; or

e) Behavior or conduct in the hospital, or his/her inability to work harmoniously with others to the extent that it affects the orderly operation of the hospital or medical staff organization;

a written request for an investigation of the matter shall be addressed to the Executive Committee making specific reference to the activity or conduct which gave rise to the request.

If the affected medical staff member chooses to resign during the investigation procedure, he shall be informed that:

a) The hospital is obligated by law to complete the investigation even if he/she chooses to resign;

b) This type of resignation must be reported to the National Practitioner Data Bank and any adverse action taken as a result of the investigation will also be reported.

The practitioner shall be permitted to withdraw his/her resignation within 15 days if he/she chooses to cooperate with the investigation and/or proceed with due process procedures as applicable.

Section 3. Investigative Procedure:

The Executive Committee shall meet as soon as possible and if, in the opinion of the Executive Committee:

a) The request for investigation contains information sufficient to warrant a recommendation, the Executive Committee shall meet with the affected individual prior to making its recommendation; or

b) The request for investigation does not contain information sufficient to warrant a recommendation, the Executive Committee shall immediately investigate the matter, appoint a subcommittee to do so, or if deemed necessary appoint an investigation committee.

Such an investigating committee shall consist of three persons, any of whom may or may not hold appointments to the Medical Staff. This committee shall not include partners or associates of the affected individual or of any member of the Executive Committee. The Executive Committee, its subcommittee and the investigating committee, if used, shall have available to them the full resources of the Medical Staff and the hospital to aid in their work as well as the authority to use any outside consultants required. The individual with respect to whom an investigation has been requested shall have an opportunity to meet with the investigating committee before it makes its report. At this meeting (but not as a matter of right in advance of it), he shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in these bylaws with respect to a hearing shall apply. A summary of such interview shall be made by the investigating committee and included with its report to

Bay Medical Bylaws
(12/9/2014) 56
the Executive Committee. If a subcommittee or investigating committee was used, the Executive Committee may accept, modify or reject the recommendation it receives from the committee.

At any time during the investigation, the Executive Committee may suspend all or any part of the clinical privileges of the individual being investigated if the Executive Committee believes failure to do so may result in imminent danger to the health of any individual and shall be deemed administrative in nature. It shall be in effect during the investigation only, shall not indicate the truth of the charges, and shall remain in force without appeal during the course of the investigation. If a suspension is placed into effect, the investigation shall be completed in 14 days or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted. If at the conclusion of the investigation, the Executive Committee recommends a reduction or suspension of clinical privileges, or a revocation of staff appointment, and also determines that failure to suspend all or any part of the clinical privileges of the individual investigated may result in an imminent danger to the health of any individual, the Executive Committee may suspend or continue to suspend such privileges. A recommendation to continue a suspension or to reduce clinical privileges shall entitle the affected individual to the procedural rights provided in Article VIII.

Section 4. Procedure Thereafter:

In acting after the investigation the Executive Committee may:

a) Issue a written warning;

b) Issue a letter of reprimand;

c) Impose terms of probation;

d) Impose a requirement for consultation;

e) Recommend reduction of clinical privileges;

f) Recommend suspension of clinical privileges for a term; or

g) Recommend revocation of staff appointment.

Any recommendation by the Executive Committee for reduction of clinical privileges, or suspension of clinical privileges for a month or more from the time the Executive Committee acts, or for revocation of staff appointment, shall entitle the affected individual to the procedural rights provided in Article VIII. Such a recommendation shall be forwarded to the chief executive officer who shall promptly notify the affected individual by certified mail, return receipt requested or by hand delivery. The chief executive officer shall then hold the recommendation until after the individual has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII. At the time the individual has been deemed to have waived his/her right to a hearing, the chief executive officer shall forward the recommendation of the Executive Committee, together with all supporting documentation, to the Board. The chairman of the Executive Committee or his/her designee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

Bay Medical Bylaws
(12/9/2014)
If the action of the Executive Committee is less severe than reduction of clinical privileges, or suspension of clinical privileges for a term of a month or more, or revocation of staff appointment, it shall not take effect until the affected individual has had an opportunity to meet with the Executive Committee. This meeting shall not constitute a hearing, and none of the procedural rules provided in these bylaws with respect to hearings shall apply. A report of the action taken and reasons therefore shall be made to the Board through the chief executive officer or designee, and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Executive Committee and such action would reduce clinical privileges, suspend clinical privileges for a month or more, or revoke staff appointment, it shall so notify the affected individual through the chief executive officer or designee, and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in Article VIII.

The chairman of the Executive Committee shall promptly notify in writing the chief executive officer or designee of all requests for action it has received regarding a person currently appointed to the Medical Staff and keep the chief executive officer or designee fully informed of all action taken in connection therewith.

The Board of Trustees shall act on the recommendation of the Executive Committee at their next regular meeting or within 45 days, whichever occurs sooner. If an appellate review is requested due to a negative recommendation from the Executive Committee, due process procedures for appeals as outlined in Article VIII shall apply.

ARTICLE VII - PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Section 1. Grounds for Summary Suspension:

The president of the Medical Staff, the chairman of a clinical department, the chief executive officer or in his/her absence a designee, the Executive Committee, or the chairman of the Board of Trustees shall each have the authority to summarily suspend all or any portion of the clinical privileges of a medical staff appointee or other individual whenever there is a belief that failure to suspend all or any part of the clinical privileges of the individual may result in an imminent danger to the health of an individual or may disrupt the operations of the hospital and such action is in the best interest of patient care or safety. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.

Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the chief executive officer or his/her designee and the president of the Medical Staff, and shall remain in effect for a period limited to 14 days while an investigation is completed. If the investigation cannot be completed within 14 days, the reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted.
Section 2. Executive Committee Procedure:

The individual who exercises his/her authority under Article VII, Part D, and Section 1 to suspend summarily a person appointed to the Medical Staff shall immediately report his/her action to the chairman of the Executive Committee to take further action in the matter. At that point, the Executive Committee shall meet in special session as soon as is practicable and shall take such further action as is required in the manner specified under Part C of this Article VII.

Section 3. Care of Suspended Individual’s Patients:

Immediately upon the imposition of a summary suspension the appropriate department chairman, or in his/her absence the president of the Medical Staff, shall assign to another person appointed to the Medical Staff the responsibility for care of the suspended individual’s patients still in the hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered in the selection of a substitute. It shall be the duty of the president of the Medical Staff and the department chairman to cooperate with the chief executive officer in enforcing all suspensions. The suspended physician’s call responsibilities will be re-assigned by the chairman of the clinical department or practice group in which the suspended physician has membership.

ARTICLE VII - PART E: AUTOMATIC SUSPENSION, AUTOMATIC RELINQUISHMENT, AND AUTOMATIC RESIGNATION

Automatic suspensions, automatic relinquishments and automatic resignations referenced in the Bylaws and the Rules and Regulations do not constitute professional review actions and members are not entitled to fair hearings and/or appeals at the hospital in connection with such actions.

Section 1. Action by State Licensing Agency:

Action by the appropriate state licensing agency revoking or suspending an individual’s professional license shall result in automatic relinquishment of all hospital privileges as of that date, until the matter is resolved and the license restored.

Section 2. Other Automatic Actions

Automatic suspensions, automatic relinquishments and automatic resignations that do not constitute professional review actions including but not limited to the following:

- Article III, Sec. 2: Failure to attend a mandatory meeting as directed by the Executive Committee.
- Article VI, Part A, Sec. (b)(4). Failure to obtain board certification within the allotted time.
- Article VI, Part B, Sec. 1. Appointee’s failure to activate membership and privileges within the allotted time.
- Article VI, Part B, Sec. 4. Failure to submit a letter of resignation or request for leave of absence within the allotted time.
• Article VI, Part G. Expiration or termination of temporary privileges.
• Article VII, Part A, Sec. 4. Failure to submit results of physical or mental examination.
• Article VII, Part F. Failure to request reinstatement following leave of absence.
• Rules and Regulations, Article XI, Section 9. Failure to complete medical records within the allotted time.
• Rules and Regulations, Article XV, Section 2. Termination of disaster privileges.

ARTICLE VII - PART F: PROCEDURE FOR LEAVE OF ABSENCE

An appointee to the Medical Staff may request a voluntary leave of absence from the staff for medical, military, training or education sabbatical, or personal reasons. A leave of absence shall not be used to evade emergency service call responsibilities. A provisional member of the Medical Staff may not request a leave of absence. The medical staff application fee shall be waived for an active or provisionally active medical staff member who resigns in good standing and decides to reapply to the Medical Staff within one year of resigning.

A written request for the leave of absence must be submitted to the Executive Committee and the chief executive officer stating the period of time and reason for the leave. The request for the leave of absence must be submitted no less than 30 days prior to the first day of leave requested except in extreme emergency cases. All requests for leave for personal reasons must be evaluated by the Medical Staff Assistance Committee for recommendation to the Executive Committee.

When the leave is requested due to illness or disability, documentation must be provided by the appointee’s treating physician stating diagnosis and anticipated length of medical leave. Requests for leave due to military obligations will also require submission of documentation. All requests for leave for personal reasons must be evaluated by the Medical Staff Assistance Committee for recommendation to the Executive Committee. A leave of absence may be granted by the medical staff committee subject to such conditions or limitations as the committee shall determine to be appropriate.

At least 30 days prior to the termination of leave or at any earlier time, the staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the chief of staff for transmittal to the Executive Committee. He/she shall submit a written summary of his/her relevant activities during the leave, if the Executive Committee or Board of Trustees so requests. When the leave is requested for medical reasons, the request for reinstatement must include information from the treating physician specifying any mental or physical limitations or disabilities that might affect his/her exercise of clinical privileges in this hospital.

Failure, without good cause, to request reinstatement or provide a requested summary of activities before termination of a leave shall result in automatic voluntary resignation of medical staff appointment, privileges and prerogatives without right of hearing or appellate review. A request for medical staff
appointment and privileges subsequently received for a medical staff appointee so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

A physician who was previously granted a leave of absence and then returns to the Medical Staff must remain on staff for at least 12 months before he/she can request another leave of absence. Physicians who do not practice medicine in their specialty during their leave of absence must return to staff at provisional status for a minimum of 12 consecutive months.
DUE PROCESS PROCEDURES

ARTICLE VIII
HEARING AND APPEAL PROCEDURES

ARTICLE VIII - PART A: INITIATION OF HEARING

An applicant or person holding a medical staff appointment shall be entitled to a formal hearing whenever a recommendation unfavorable to him has been made by the Executive Committee regarding those matters enumerated in Section 2 of this Article.

ARTICLE VIII - PART B: THE HEARING

Section 1. Notice of Recommendation:

a) When a recommendation is made which according to these bylaws entitles an individual to a formal hearing prior to a final decision of the Board on that recommendation, the applicant or medical staff appointee, as the case may be, shall promptly be given notice by the chief executive officer or designee by certified mail with return receipt requested and/or hand delivery. This notice shall contain a statement of the recommendation made and a summary of the rights of the physician at the hearing, including the following:

1) That an action listed in Article VIII Section 2 has been proposed to be taken against him by the Executive Committee;
2) The reasons for the proposed action;
3) That the applicant/member has the right to request a hearing on the proposed action within thirty (30) calendar days after receiving written notice of an adverse recommendation or decision;
4) That at the hearing the applicant/member has the right:
   i) to be represented by an attorney or other persons of his/her choice;
   ii) to have a record made of the hearing, a copy of which may be obtained upon payment of any reasonable charge associated with the preparation thereof;
   iii) to call, examine and cross-examine witnesses;
   iv) to present evidence determined to be relevant by the Hearing Officer or Panel Chair, regardless of its admissibility in a court of law;
   v) to submit a written statement at the close of the hearing;
   vi) to receive, upon completion of the hearing, the written recommendation of the hearing panel, including a statement of the basis for the recommendation; and
   vii) to receive the final decision of the hospital, including a statement of the basis of the decision; and
(viii) the failure of an applicant/member to request a hearing to which he/she is entitled by these Bylaws within thirty (30) calendar days after receiving written notice of an adverse recommendation or decision, in the manner herein provided, shall be considered a waiver of his right to such hearing to which he is entitled by these Bylaws and an immediate acceptance of the adverse recommendation or decision and such action shall thereupon become effective immediately upon final Board action.

Section 2. Ground for Hearing

No matter or action other than those Executive Committee recommendations hereinafter enumerated shall constitute grounds for a hearing:

a) Denial of initial medical staff appointment;
b) Denial of requested advancement in medical staff category;
c) Denial of medical staff re-appointment;
d) Revocation of medical staff appointment;
e) Denial of all or any portion of requested initial clinical privileges;
f) Denial of all or any portion of requested increased clinical privileges;
g) Decrease of all or any portion of clinical privileges;
h) Continuation of a suspension of all or any portion of clinical privileges for more than thirty (30) calendar days;
i) Recommendation of suspension of all or any portion of clinical privileges to be in place for more than thirty (30) calendar days;
j) Denial of reinstatement after a leave of absence; and or
k) Imposition of a mandatory concurring consultation or proctoring requirement wherein the consulting physician must approve the treatment or surgery before it occurs or proctoring physician has the right to intervene in the treatment and/or surgery of a patient.

When any member receives notice of one of these decisions by the Board and this decision is not based on a prior adverse recommendation by the Executive Committee, the applicant/member shall be entitled to a hearing under this Article.

Section 3. Unappealable Actions:

Automatic suspensions, automatic terminations, voluntary or automatic resignations or relinquishment of clinical privileges, as provided for in Article VII Part E and elsewhere in these bylaws, nor the imposition of any consultation requirement except as set forth in Section 2.k) of this Article, nor the imposition of a requirement for retraining or additional training, no matter whether imposed by the Executive Committee or the Board, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.
Section 4. Notice of Hearing and Statement of Reasons:

The chief executive officer shall schedule the hearing and shall give notice by certified mail with return receipt requested or hand delivery, to the person who requested the hearing of its time, place and date. The hearing shall begin as soon as practicable, considering the schedules and availability of all concerned but shall be set no less than 30 days after the hearing notice is received.

This notice shall contain a statement of the reasons for the recommendation as well as the patient records and information supporting the recommendation. The notice of hearing shall also contain a listing of witnesses expected to testify on behalf of the Medical Staff. The notice of hearing shall also state that at the hearing the applicant/member has the right:

a) to representation by an attorney or other persons of the physician’s choice;
b) to have a record made of the hearing, a copy of which may be obtained by the applicant/member upon payment of any reasonable charge associated with the preparation thereof;
c) to call, examine and cross-examine witnesses;
d) to present evidence determined to be relevant by the Hearing Officer or Panel Chair, regardless of its admissibility in a court of law;
e) to submit a written statement at the close of the hearing;
f) to receive, upon completion of the hearing, the written recommendation of the hearing panel, including a statement of the basis for the recommendation; and

g) to receive the final decision of the hospital, including a statement of the basis of the decision.

This statement and the patient records and information it contains may be amended or added to at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the person requesting the hearing, and that person and his/her counsel have sufficient time to study this additional information and rebut it.

Section 5. List of Witnesses:

If either party by notice requests a list of witnesses, then each party within 10 days of such request shall furnish to the other a written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing, and the names and addresses of additional witnesses as soon as procured. The witness list of either party may, in the discretion of the hearing officer, may, be supplemented at any time during the course of the hearing.

Section 6. Section 6. Hearing Panel:

When a hearing is requested, the chief executive officer, acting for the Board and after considering the recommendations of the president of the Medical Staff and the chairman of the Board, shall appoint a hearing panel which shall be composed of not less than three members, at least a majority of whom shall Bay Medical Bylaws

(12/9/2014)  64
be physicians who are active appointees of the Medical Staff. The panel shall be composed of either medical staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level or of physicians of laymen not connected with the hospital or a combination of such persons. No member of the hearing panel may be in direct competition with the physician requesting the hearing. Such appointment shall include designation of the chairman. Knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel.

Section 7. Section 7. Failure to Appear:

Failure, without good cause, of a person requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

Section 8. Section 8. Postponements and Extensions:

Postponements and extensions of time beyond any time limit set forth in these bylaws may be requested by anyone but shall be permitted only by the hearing panel or its chairman on a showing of good cause.

Section 9. Deliberations and Recommendations of the Hearing Panel:

Within 20 days after final adjournment of the hearing, the hearing panel shall conduct its deliberation outside the presence of any other person except the hearing officer and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report to the chief executive officer or designee.

Section 10. Disposition of Hearing Panel Report:

Upon its receipt the chief executive officer or designee shall send a copy of the report and recommendation, by certified mail with return receipt requested, to the person who requested the hearing. If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, the report of the hearing panel shall be delivered by the chief executive officer or designee to the applicable committee for whatever modification, if any, it may wish to make to its original recommendation. If it has been conducted by reason of an action of the Board or its committee, the report of the hearing panel shall be delivered to the Board or that committee.

ARTICLE VIII - PART C: HEARINGPROCEDURE

Section 1. Representation:

The person requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine witnesses and present his/her case. He shall inform the chief executive officer or designee in writing of the name of that person 10 days prior to the date of the hearing. The Executive Committee or the chief executive officer acting for the Board, whichever is appropriate, shall appoint a representative who may be an attorney to present its recommendations and to examine witnesses.
Section 2. Hearing Officer:

The chief executive officer may appoint an attorney at law as hearing officer. Such hearing officer may be legal counsel to the hospital. He must not act as a prosecuting officer or an advocate for the Board or the Executive Committee. He may participate in the private deliberations of the hearing panel and be a legal advisor to it, but he shall not be entitled to vote on its recommendations. He may thereafter continue to advise the Board on the matter.

Section 3. Presiding Officer:

The hearing officer shall be the presiding officer at the hearing. If no hearing officer has been appointed, the chairman of the hearing panel shall be the presiding officer. The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He shall throughout the hearing and that no intimidation is permitted. He shall determine the order of procedure throughout the hearing and shall have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence, upon which he may be advised by legal counsel to the hospital. In all instances he shall act in such a way that information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the hearing panel in formulating its recommendations. It is understood that the hearing officer is acting at all times to see that all relevant information is made available to the hearing panel for its deliberations and recommendations to the Board.

Section 4. Record of Hearing:

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this state.

Section 5. Rights of Both Sides:

At a hearing, both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witnesses on any matter relevant to the issues; to rebut any evidence. If the person requesting the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross examination.

Section 6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a
memorandum of points and authorities, and the hearing panel may request such a memorandum to be filed following the close of the hearing. The hearing panel may interrogate the witnesses; call additional witnesses or request documentary evidence if it deems it appropriate.

Section 7. Official Notice:

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

Section 8. Basis of Decision:

The decision of the hearing panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

a) Oral testimony of witnesses;

b) Memorandum of points and authorities presented in connection with the hearing;

c) Any material contained in the hospital’s files regarding the person who requested the hearing so long as this material has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

d) Any and all applications; references and accompanying documents;

e) All officially noticed matters; and

f) Any other admissible evidence.

Section 9. Burden of Proof:

a) At any hearing involving any of the following grounds for hearing: denial of initial medical staff appointment, denial of requested advancement in medical staff category, denial of medical staff reappointment, revocation of medical staff appointment, or denial of a request for initial or additional clinical privileges, it shall be incumbent on the person who requested the hearing initially to come forward with evidence in support of his/her position.

b) In cases involving a decrease of clinical privileges or a suspension of privileges, it shall be incumbent on the Board or the Executive Committee, whichever recommendation prompted the hearing initially, to come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in his/her support.

Bay Medical Bylaws
(12/9/2014) 67
c) In all cases in which a hearing is conducted under this Article, after all the evidence has been submitted by both sides, the hearing panel shall recommend against the person who requested the hearing unless it finds that said person has proved that the recommendation which prompted the hearing was unreasonable, not sustained by the evidence or otherwise unfounded.

Section 10. Attendance by Panel Members:

Recognizing that it may not be possible for all members of the hearing panel to be present continually at all sessions of the panel, since it is necessary to conduct a hearing as soon as reasonable after the event or events that gave rise to its necessity, the hearing shall continue even though certain members of the hearing panel are not present at all time. The fact that certain panel members were not physically present at all times during the hearings will not disqualify them or invalidate the hearing. Consequently, no quorum of the hearing panel shall be required in order to continue the hearing. The vote shall be by majority of those appointed to the hearing panel.

Section 11. Adjournment and Conclusion:

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Neither side shall be permitted to make any changes to the documentation, facts or issues after the hearing has been closed. If an appeal is requested, the appeal must be based solely on the record existent at the closure of the hearing.

ARTICLE VIII - PART D: APPEAL

Section 1. Time for Appeal:

Within 15 days after the affected individual is notified of either:

   a) A final recommendation adverse to him/her made by the Executive Committee after a hearing, if he/she has requested one; or

   b) And adverse recommendation from a hearing panel directly to the Board, he/she may request an appellate review. The request shall be in writing and shall be delivered to the chief executive officer either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within 15 days as provided herein, the affected individual shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective.

Section 2. Grounds for Appeal:

The grounds for appeal from an adverse recommendation shall be that:

Bay Medical Bylaws
(12/9/2014)  68
a) There was substantial failure on the part of the Executive Committee or hearing panel to comply with the hospital or medical staff bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or

b) The recommendation was made arbitrarily, capriciously or with prejudice; or

c) The recommendation of the Executive Committee or the hearing panel was not supported by the evidence.

Section 3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall, within 10 days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause the affected individual to be given notice of the time, place and date of the appellate review. The date of appellate review shall be not less than 20 days or more than 40 days from the date of receipt of the request for appellate review; provided that a request for appellate review is from an appointee who is under suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the chairman of the Board for good cause.

Section 4. Nature of Appellate Review:

The chairman of the Board shall appoint a review panel composed of not less than three (3) persons, either its own members, reputable persons outside of the hospital or a combination of the two, to consider the record upon which the recommendation before it was made. The review panel may, at their discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the hearing panel proceedings. Each party shall have the right to present a written statement in support of his/her position on appeal, and in its sole discretion, the review panel may allow each party or its representative to appear personally and make oral argument. The review panel shall recommend final action to the Board. The Board may affirm, modify or reverse the recommendation of the review panel, or at its discretion refer the matter for further review and recommendation.

Section 5. Final Decision of the Board:

Within 30 days after the conclusion of the proceedings before the review panel, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the Executive Committee by certified mail, return receipt requested or by hand delivery.

Section 6. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part D, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the
instructions given by the Board. This further review process and the report back to the Board shall in no event exceed 30 days in duration except as the parties may otherwise stipulate.

Section 7. Right to One Appeal Only:

No applicant or medical staff appointee shall be entitled as a matter or right to more than one appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the results of action by the Executive Committee or hearing panel, or a combination of acts of such bodies. However, nothing in the bylaws shall restrict the right of an appointee to apply for reappointment or an increase in clinical privileges after the expiration of two years from the date of such Board decision unless the Board provided otherwise in its written decision.

ARTICLE IX
AMENDMENTS TO MEDICAL STAFF BYLAWS

Proposed amendments of these bylaws may be initiated by the organized medical staff through a petition of ten percent (10%) or more of the voting members of the Medical Staff. The proposed amendment shall be referred to the Executive Committee for review prior to vote by the Medical Staff. The Executive Committee shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

The proposed amendments shall be voted upon by the Medical Staff at the regular or special meeting provided that they shall have been posted on the medical staff bulletin board or mailed out to the medical staff members entitled to vote at least 14 days prior to the meeting. To be adopted, an amendment must receive a majority of the votes cast by the voting staff who are present at a Medical Staff meeting where a quorum is met. Amendments so approved shall be effective when approved by the Board.

Neither the medical staff nor the Board may unilaterally amend the Bylaws, except as provided below.

The Executive Committee shall have the power to recommend provisional amendments to the bylaws as are, in the Executive Committee’s judgment, required on an urgent basis to comply with law or regulation, without prior notification of the Medical Staff. Such provisional amendments shall be effective immediately upon approval of the Board. The provisional amendments will be posted on the Medical Staff bulletin board or mailed to voting staff. The provisional amendments shall become permanent if not disapproved by the Medical Staff at a regular or special meeting called for such purpose or the Board within 60 days of adoption by the Executive Committee. If there are comments opposing the provisional amendments, the process for conflict management will be implemented.

Bay Medical Bylaws
(12/9/2014)
ARTICLE X
RULES, REGULATIONS AND POLICIES OF THE MEDICAL STAFF

The Medical Staff may adopt or amend such rules, regulations and policies as may be necessary to provide associated details and to implement more specifically the general principles of conduct found in these bylaws, and may propose such rules, regulations and policies to the Board. Rules, regulations and policies may set standards of practice that are to be required of each physician, dentist, and podiatrist and licensed independent allied health practitioners in the hospital and shall act as an aid to evaluating performance under and in compliance with these standards. Rules, regulations and policies shall have the same force and effect as the bylaws.

Proposed rules, regulations and policies or amendments to such rules, regulations and policies may be initiated by the organized medical staff through a petition of ten percent (10%) or more of the voting members of the Medical Staff. The proposal shall be referred to the Executive Committee for review prior to vote by the Medical Staff. Rules, regulations and policies may also be amended, repealed or added by the Medical Staff at regular meeting or special meeting called for that purpose, provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Board.

The Executive Committee may also propose rules, regulations and policies, or amendments to these documents. If the Executive Committee proposes rules, regulations and policies or amendments, it shall report on the proposal either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. Particular rules, regulations and policies may be amended, repealed or added by vote of the Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions or repeals are sent to all Executive Committee members 14 days before being voted on and submitted to the Board, and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff be brought to the attention of the Executive Committee before the amendment, repeal or addition is voted on.

Any proposed rules, regulations and policies and amendments shall become effective only when approved by the Board. Medical Staff members may communicate with the Board regarding any rules, regulations or polices in the manner determined by the Board.

Neither the medical staff nor the Board may unilaterally amend the rules, regulations and policies.

ARTICLE XI
CONFLICT RESOLUTION

Any conflict between the Organized Medical Staff, the Executive Committee, and/or the Board will be resolved using the mechanisms noted below:

Bay Medical Bylaws
(12/9/2014)
Each voting Member of the Medical Staff may challenge any rule, regulation or policy established by the Executive Committee through the following process:

(1) Submission of written notification to the President of the Medical Staff of the challenge and the basis for the challenge including any recommended changes to the Rule and Regulation or Policy.

(2) At the meeting of the Executive Committee that follows such notification, the Medical Executive Committee shall discuss the challenge and determine if any changes will be made to the rule, regulation or policy.

(3) If changes are adopted, they will be communicated to the Medical Staff, at such time Members of the Organized Medical Staff with voting privileges may submit written notification of any further challenge(s) to the Rule, Regulation, or Policy to the President of the Medical Staff.

(4) In response to a written challenge to a Rule, Regulation, or Policy, the Medical Executive Committee may, but is not required to, appoint a task force to address concerns raised by the challenge.

(5) If a task force is appointed, following the recommendations of such task force, the Medical Executive Committee will take final action on the Rule or Policy.

(6) Once the Medical Executive Committee has taken final action in response to the challenge, with or without recommendations from a task force, any Medical Staff Member may submit a petition signed by twenty-five percent (25%) of the Members of the Organized Medical Staff with voting privileges requesting review and possible change of the Rule, Regulation, or Policy. Upon presentation of such a petition, the adoption procedure outline in this Article will be followed.

If the Medical Staff votes to recommend directly to the Board an amendment to the Bylaws, Rules or Regulation, or Policy that is different from what has been recommended by the Medical Executive Committee, the following process shall be followed:

(7) The Medical Executive Committee shall have the option of appointing a task force to review the differing recommendations of the Medical Executive Committee and the Medical Staff, and recommend language to the Bylaws, Rules and Regulations, or Policy that is agreeable to both the Medical Staff and the Medical Executive Committee.

(8) Whether or not the Medical Executive Committee adopts the modified language, the Medical Staff shall have the opportunity to recommend directly to the Board alternative language. If the Board receives differing recommendations for Bylaws, Rules and Regulations, or Policy from the Medical Executive Committee and the Medical Staff, the Board shall have the option of appointing a task force of the Board to study the basis of the differing recommendations and to recommend appropriate Board action. Whether or not the Board appoints such a task force, the Board shall have final authority to resolve the differences between the Organized Medical Staff and the Medical Executive Committee.

At any point in the process of addressing a disagreement between the Medical Staff and the Medical Executive Committee regarding the Bylaws, Rules and Regulations, or Policy, the Organized Medical Staff, Medical Executive Committee, or Board shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed in so doing, is the responsibility of the Governing Board.