

**MEDICAL STAFF**

**BYLAWS**

**OF**

**THE CLINTON HOSPITAL AUTHORITY**

**D/B/A**

**CLINTON REGIONAL HOSPITAL**

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CLINTON REGIONAL HOSPITAL**

**PREAMBLE**

- A. The Clinton Hospital Authority d/b/a Clinton Regional Hospital (“Hospital”) is a public trust organized under the laws of the State of Oklahoma for the purpose of formed to operate an acute care hospital and related entities to provide health care and medical services for inpatients and outpatients and to promote the well-being of the citizens of Clinton, Oklahoma and the surrounding area.
- B. The Board of Trustees of Hospital is the policy making body responsible for the overall operation of Hospital and has charged the Medical Staff of Hospital with the responsibility for providing, monitoring and improving patient care in the Hospital.
- C. The Medical Staff of Hospital shall organize their activities in conformity with these Bylaws to carry out the functions delegated to the Medical Staff by the Board of Trustees.

**DEFINITIONS**

Words used in these Bylaws shall be construed to refer to the masculine or feminine gender and to singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

- 1. **Appellate Review Body** means the group designated to conduct an appellate review pursuant to a request properly filed and pursued by a Practitioner as provided in Article 12 of the Medical Staff Bylaws.
- 2. **Allied Health Professional** or “AHP(s)” means those individuals identified and described in Article 4, Sections 4.1 and 4.2, of the Medical Staff Bylaws.
- 3. **Applicant** means a Physician, Podiatrist or Psychologist [list other practitioners eligible for Medical staff membership] \_\_\_\_\_ who requests to join the Medical Staff or obtain Privileges at Hospital.
- 4. **Application** means an application for appointment to the Medical Staff as described in Article 5, Sections 5.3 and 5.4, of the Medical Staff Bylaws.
- 5. **Chief Executive Officer** is the individual appointed by the Board of Trustees to oversee the overall administration of the Hospital.
- 6. **Chief of Staff** is the chief administrative officer of the Medical Staff as described in Article 6 of the Medical Staff Bylaws.
- 7. **Clinical Privileges** or **Privileges** mean the permission granted to a Practitioner or Allied Health Professional to render specific diagnostic, therapeutic, medical, dental or surgical services within the Hospital.
- 8. **Dentist** means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in Oklahoma.
- 9. **Medical Executive Committee** shall mean the executive committee of the Medical Staff provided for in Article 9 of the Medical Staff Bylaws.

10. **Good Standing** means that the Medical Staff Member, at the time the issue is raised, has met the attendance and committee participation requirements during the previous Medical Staff Year, is not in arrears in dues payments, and has not received a suspension or restriction of the Medical Staff Member's appointment, admitting or Clinical Privileges in the previous twelve (12) months; provided, however, that if a Medical Staff Member has been suspended in the previous twelve (12) months for failure to comply with Hospital's policies or regulations regarding medical records and has subsequently taken appropriate corrective action, such suspension shall not adversely affect the Medical Staff Member's Good Standing status.
11. **Governing Body, Board of Trustees or Board** means the Board of Trustees of Hospital organized under the applicable laws and regulations of the State of Oklahoma.
12. **Hearing Committee** means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner in accordance with Article 12 of these Medical Staff Bylaws.
13. **Hospital** means The Clinton Hospital Authority d/b/a Clinton Regional Hospital, located in Clinton, Oklahoma.
14. **Hospital Bylaws** mean those Bylaws established by the Board.
15. **Hospital Corporate Compliance Plan** means the Corporate Compliance Plan and any related policies and procedures adopted by the Board to promote Hospital's compliance with applicable laws and regulations.
16. **Hospital Representative** means the Board of Trustees and any director or committee thereof; the Hospital Chief Executive Officer or the Chief Executive Officer's designee; other employees of the Hospital; a Medical Staff organization or any member, officer, clinical division or committee thereof; and any individual appointed or authorized by any of the foregoing Hospital Representatives to perform specific functions related to gathering, analysis, use or dissemination of information.
17. **Medical Staff** means the Practitioners who have obtained membership status and have been granted Privileges that allow them to attend to patients and/or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.
18. **Medical Staff Bylaws** mean these Bylaws covering the operations of the Medical Staff of Hospital.
19. **Medical Staff Rules and Regulations** mean the rules and regulations adopted by the Medical Staff and approved by the Board.
29. **Medical Staff Year** is defined as the twelve (12) month period beginning on January 1 and ending on December 31.
21. **Peer Review Committee** means a committee established by the Hospital or the Medical Staff for the purposes of conducting peer review or participating in the peer review process pursuant to 63 O.S. §1-1709.1.
22. **Physician** means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in the State of Oklahoma.
23. **Physician Coordinator** means an Active Medical Staff Member who has been appointed in accordance with and has the qualifications and responsibilities for service administration as outlined in Article 8, Sections 8.3 and 8.4, and throughout these Bylaws.
24. **Podiatrist** means an individual who has received a Doctor of Podiatric Medicine degree and is currently fully licensed to practice podiatric medicine in the State of Oklahoma.

25. **Practitioner** means, unless otherwise expressly provided, any Physician, Psychologist or Podiatrist who has either: (a) applied for appointment to the Medical Staff and for Clinical Privileges; or (b) been granted an appointment to the Medical Staff and holds specific delineated Privileges; or (c) has applied for or has been granted temporary Privileges pursuant to Article 6, Section 6.10, of these Bylaws.
26. **Prerogative** means the right to participate, by virtue of Staff category or otherwise, granted to a Medical Staff Member or Allied Health Professional, and subject to the ultimate authority of the Board and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.
27. **Psychologist** means an individual who has obtained an approved masters or doctoral degree and is currently fully licensed to practice psychology in the State of Oklahoma.
28. **Service or Clinical Service** means a grouping or division of clinical services as listed in Article 8, Section 8.2, of the Medical Staff Bylaws.
29. **Special Notice** means written notice sent via certified mail, return receipt requested or by hand-delivery evidenced by a receipt signed by the Practitioner to whom it is directed.

## ARTICLE 1 - PURPOSES AND RESPONSIBILITIES

- 1.1 Purposes. The purposes of the Medical Staff are:
  - (a) To be accountable to the Board for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff and to promote patient care at Hospital that is consistent with generally recognized standards of care;
  - (b) To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership may be fulfilled; and
  - (c) To provide an appropriate and efficient forum for Medical Staff Member input to the Board and Chief Executive Officer on Hospital and medical issues.
- 1.2 Responsibilities. The Medical Staff's responsibilities shall include:
  - (a) To participate in the performance improvement/quality assurance, quality review and utilization management of the Hospital and conduct activities required by the Hospital to assess, maintain and improve the quality and efficiency of medical care in the Hospital, including without limitation:
    - (i) Evaluating Practitioner and institutional performance through use of a valid measurement system as developed by Hospital, and based upon clinically sound criteria;
    - (ii) Monitoring critical patient care practices on an ongoing basis, including but not limited to performance of operative and other procedures;
    - (iii) Evaluating the use of medications, blood and blood products;
    - (iv) Developing clinical practice patterns and identifying and evaluating deviations from established patterns of clinical practice;
    - (v) Reviewing data and recommending and implementing processes to address operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

- (vi) Establishing criteria and evaluating Practitioner credentials for appointment and reappointment to the Medical Staff and for identifying the Clinical Privileges that are assigned to individual Practitioners and Allied Health Professionals in the Hospital;
  - (vii) Initiating and pursuing corrective action with respect to Practitioners when warranted; and
  - (viii) Identifying and advancing the appropriate use of Hospital resources available for meeting patients' medical, social and emotional needs, in accordance with sound resource utilization practices.
- (b) To ensure timely completion of medical records by a Physician or other qualified licensed individual in accordance with state law and Hospital policy, including but not limited to documentation of:
- (i) A medical history and physical examination completed no more than thirty (30) days before or twenty-four (24) hours after admission, but prior to any surgery requiring anesthesia services. If history and physical are documented prior to admission, an updated physical examination and medical history must be recorded within twenty-four (24) hours of admission, but prior to any surgery or procedure requiring anesthesia; and
  - (ii) Complete records of discharged patients consistent with Hospital medical record policies, not to exceed thirty (30) days after dismissal.
  - (iii) **[may want to address required signed, dated and timed orders for diagnostic tests and the certification and re-certification issues for Swing-bed.]**
- (c) To make recommendations to the Board regarding Medical Staff appointment and reappointment, including category and Service assignments, Clinical Privileges, and corrective and/or disciplinary action.
- (d) To assist in the development, delivery and evaluation of continuing medical education and training programs.
- (e) To develop and maintain Medical Staff Bylaws and policies that promote sound professional practices, organizational principles and compliance with federal and state law requirements, and to enforce compliance with such Medical Staff Bylaws, policies and laws.
- (f) To participate in the Hospital's long-range planning activity, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.
- (g) To fulfill the obligations and appropriately use the authority granted in these Medical Staff Bylaws in a timely manner through the use of Medical Staff officers, committees and individuals and to account to the Board.
- (h) To assure that at all times at least one (1) Physician member of the Medical Staff shall be on duty or available within a reasonable period of time for emergency service.

## ARTICLE 2 - MEMBERSHIP

- 2.1 Nature of Membership. No person, including those with a contract of employment with the Hospital, may admit or provide any health care services to patients in the Hospital unless the person is a Medical Staff Member or has been granted Clinical Privileges in accordance with the procedures set forth in these Medical Staff Bylaws.

- (a) Medical Staff appointment shall confer only the Clinical Privileges and Prerogatives granted by the Board in accordance with these Bylaws that are commensurate with the member's qualifications, experience, present capabilities and scope of practice.
- (b) No Applicant shall be denied membership on the basis of sex, race, creed, color, national origin, age or a handicap unrelated to the ability to fulfill patient care and required Staff obligations.
- (c) No Practitioner shall be granted or denied Medical Staff membership or the exercise of particular Clinical Privileges at the Hospital solely because the Practitioner:
  - (i) Holds a current license or obtained a professional degree recognized by the State of Oklahoma;
  - (ii) Holds a particular certification or fellowship; completed a general practice residency; or is a member of a specialty board, society or body; or
  - (iii) Has previously had Medical Staff membership or Privileges in this Hospital, or is a current or former Medical Staff Member, or holds or has held Privileges in any other hospital or other health care facility.
- (d) No application for membership on the Medical Staff shall be denied based solely upon the Applicant's professional degree or the school or health care facility in which the Practitioner received medical, psychology or podiatry schooling, postgraduate training or certification, if the schooling or postgraduate training for a Physician was accredited by the American Medical Association or the American Osteopathic Association; and for a Podiatrist, was accredited by the American Podiatric Medical Association.

2.2 Qualifications for Membership. Every Practitioner who applies for or holds Medical Staff appointment must, at the time of Application and initial appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board that the Practitioner meets all of the following qualifications for membership and any other qualifications and requirements as set forth in these Medical Staff Bylaws, the Medical Staff Rules and Regulations, Hospital Bylaws, policies and rules, Hospital Corporate Compliance Plan, and other requirements or policies established by the Board.

- (a) Has current valid license issued by the State of Oklahoma to practice as a Physician, Psychologist or Podiatrist, and has current, valid DEA registration, if applicable.
- (b) Has documentation of graduation from a school with certification by the Accreditation Counsel for Graduate Medical Education; Educational Council for Foreign Medical Graduate and on the passage of the Foreign Medical Graduate Examination in the Medical Sciences; or other applicable accreditation. Physicians shall provide documentation of satisfactory completion of an approved internship or residency. Fellowship in an institution approved for residency training shall be regarded as residency training or internship.
- (c) Has documentation evidencing an ongoing ability to provide patient care services consistent with acceptable standards of practice and available resources, including current experience, clinical results and utilization practice patterns.
- (d) Has demonstrated ability to work with and relate to people, including other Medical Staff Members, Hospital employees and administration, the Board, patients and visitors, and the community in general, in a cooperative, professional manner that maintains and promotes an environment of quality and efficient patient care.

- (e) Has been in compliance with the obligations of Staff appointment as set forth in Section 3.3 of this Article III and equitable participation in the performance of Staff obligations.
- (f) Adheres to generally recognized standards of medical and professional ethics.
- (g) Demonstrates freedom from, or adequate control over, any physical or mental impairment that would significantly affect the Practitioner's ability to practice, including, but not limited to, abuse of any type of substance or chemical that affects cognitive, motor or communication ability in any manner that interferes with, or has a reasonable probability of interfering with the qualifications for membership such that patient care is, or is likely to be, adversely affected.
- (h) Has the ability to read and understand the English language, to communicate effectively and intelligibly in the English language (written and verbal), and to prepare medical record entries and other required documentation in a legible and professional manner.
- (i) Has professional liability insurance of such kind, in such amount, and underwritten by such insurers as required by Oklahoma law or as required from time to time by resolution of the Board after consultation with the Medical Executive Committee, whichever requirement is more stringent.
- (j) Has never been convicted of a felony or a misdemeanor related to the Practitioner's suitability to practice the Practitioner's profession.
- (k) Is not currently excluded from or sanctioned by the Medicare or Medicaid programs or any other state or federal governmental program, and is not on the U.S. Department of Health and Human Services Office of Inspector General list of excluded providers.
- (l) In the case of new Applications for Medical Staff appointment and Clinical Privileges and with respect to Applications for changes in Clinical Privileges, the requested appointment/Privileges/affiliation must be compatible with any policies, plans or objectives formulated by the Board concerning:
  - (i) The Hospital's patient care needs, including current needs and projected needs;
  - (ii) The Hospital's ability to provide the facilities, personnel and financial resources that will be necessary if the Application is approved; and
  - (iii) The Hospital's decision to contract exclusively for the provision of certain medical services with a Physician or a group of Physicians other than the affected Practitioner.

2.3 Obligations of Staff Membership. Each member of the Medical Staff and each Practitioner granted temporary Privileges under these Bylaws must:

- (a) Provide the Practitioner's patients with generally recognized professional services consistent with the recognized standards of practice in the same or similar communities and the resources locally available;
- (b) Comply with these Bylaws; the Medical Staff Rules and Regulations; the Hospital Bylaws, policies and rules; the Hospital's Corporate Compliance Plan; and all other standards, policies and rules of the Staff, the Hospital, and state and federal law;
- (c) Perform any Staff, committee and Hospital functions for which the Practitioner is responsible;
- (d) Complete medical records and other records in such manner and within the time period required by Hospital for all patients the Practitioner admits or in any way provides care for in the Hospital;

- (e) Abide by generally recognized standards of professional ethics; and
- (f) Satisfy the continuing education requirements established by the Medical Staff. Practitioner's failure to satisfy any of the aforementioned qualifications or obligations may be grounds for denial of reappointment to the Staff, reduction in Staff category, restriction or revocation of Clinical Privileges, or other disciplinary action as determined in a final action of the Board pursuant to Article 11 of these Bylaws.

2.4 Duration of Appointment.

- (a) Initial appointment shall be for a period extending to the end of the current Medical Staff year. Reappointment shall be for a period of not more than two (2) Medical Staff years. Provided, however, that the duration of any such initial appointment or reappointment shall be subject to the provisions of Article 11.
- (b) Notwithstanding the foregoing, in the case of a Practitioner providing professional services by contract with or employment by the Hospital, termination or expiration of the contract or employment or the failure to renew the contract may result in a shorter period of appointment or Clinical Privileges.
- (c) If the Hospital adopts a policy involving a closed Service or an exclusive arrangement for a particular service or services, any Practitioner who previously held Privileges to provide such services but who is not a party to the exclusive contract/arrangement will have the Privileges for the performance of such services terminated as of the effective date of the closure of the Service or exclusive arrangement, irrespective of any remaining time on the appointment or reappointment term.

2.5 Procedures for Appointment and Reappointment. The mechanics for evaluating Applications for initial appointment and for conducting periodic reappraisals for reappointment to the Staff are outlined in Article 5 of these Bylaws.

2.6 Contract Practitioners.

- (a) A Practitioner who is or who will be providing specified professional services pursuant to a contract with the Hospital is subject to all membership qualifications, appointment, reappointment and Clinical Privilege evaluations, and must meet all of the obligations of membership, just as any other Applicant or Staff Member.
- (b) The Staff appointment and Clinical Privileges of any Staff Member who has a contractual relationship with the Hospital, or is either an agent, employee or principal of, or partner in, an entity that has a contractual relationship with the Hospital relating to providing services to patients at the Hospital, shall terminate subject to extension by the affirmative act of the Board upon:
  - (i) The expiration or other termination of the contractual relationship with the Hospital; or
  - (ii) The expiration or other termination of the relationship of the Staff Member with the entity that has a contractual relationship with the Hospital.

In the event of a termination of Staff appointment and/or Clinical Privileges due to Section 2.6(b)(i) or (b)(ii) above, no right to a hearing or appellate review provided in these Bylaws, including those provided in Article 12, shall apply. Otherwise, nothing herein shall limit the Staff Member's procedural due process rights.

## 2.7 Leave of Absence.

- (a) Upon a showing of good cause, Staff Members may be granted leaves of absence by the Medical Executive Committee, subject to approval by the Board, for a definitely stated period of time not to exceed six (6) months. Absence for longer than six (6) months shall constitute voluntary resignation of Medical Staff appointment and Clinical Privileges unless, upon good cause shown, the Medical Executive Committee grants an exception.
- (b) Requests for leaves of absence shall be made to the Chief of Staff and shall state the beginning and ending dates of the requested leave.
- (c) During the leave of absence, the Staff Member is not entitled to Clinical Privileges at the Hospital, and has no membership rights and responsibilities, but must continue to pay Medical Staff dues, unless otherwise waived by the Medical Staff. Prior to a leave of absence being granted, the Medical Staff Member shall have made arrangements that are acceptable to the Medical Executive Committee and Board for the care of the Staff Member's patients during the leave of absence.
- (d) If the leave of absence is for reasons other than medical reasons, the Staff Member may be reinstated at the conclusion of the leave of absence upon filing with the Chief of Staff a written request for reinstatement and a statement summarizing continuing education, licensure or other activities related to the member's Clinical Privileges undertaken during the leave of absence. The Staff Member also shall submit such other information as requested by the Medical Executive Committee.
- (e) If the leave of absence is for medical reasons, the Staff Member must submit to the Medical Executive Committee a written request for reinstatement as well as a report from the Staff Member's attending Physician indicating that such Staff Member is physically and/or mentally capable of resuming a Hospital practice, with or without accommodation and, if with accommodation, the nature of the needed accommodation. The Staff Member also shall provide such other information as may be requested by the Medical Executive Committee.
- (f) In acting upon the request for reinstatement, the Medical Executive Committee may approve reinstatement either to the same or a different Staff category and may limit or modify the Clinical Privileges to be extended to the Staff Member upon reinstatement, subject to approval by the Board.

## **ARTICLE 3 - MEDICAL STAFF CATEGORIES**

3.1 Categories. The Medical Staff shall be divided into the following categories: Active, Courtesy, Consulting, Honorary, Emergency Room, Telemedicine, *Locum tenens*, Dentists, Psychologists and Podiatrists.

### 3.2 Active Staff.

- (a) Qualifications: An Active Staff Member must:
  - (i) Reside or have a business office within sufficiently close proximity to the Hospital (as determined by the Medical Executive Committee) to enable the Staff Member to provide continuous care to the Staff Member's patients;

- (ii) Admit at least Twenty Four (24 ) patients per year outpatient procedures at the Hospital during each Medical Staff year or otherwise be regularly involved in the care of patients in the Hospital.
- (iii) Meet the requirements as provided in Article 2, Section 2.2. (b)

Prerogatives: An Active Staff Member may:

- (i) Admit patients without limitation, except as limited by the scope of the Staff Member's Clinical Privileges granted pursuant to Article 6 or otherwise as provided in the Medical Staff Rules and Regulations;
  - (ii) Attend regular and professional meetings of the Medical Staff and of any Medical Staff committees of which the Active Staff Member is a member;
  - (iii) Vote on all matters presented at all meetings of the Medical Staff and at all committee meetings of which the Active Staff Member is a member, except as provided by resolution of the Medical Executive Committee and approved by the Board;
  - (iv) Hold office in the Medical Staff or sit on, or act as chairperson of, any committee as determined by resolution of the Medical Executive Committee or the Board; and
  - (v) Exercise the Clinical Privileges granted to the Active Staff Member.
- (c) Obligations: In addition to the basic obligations set forth in Article 2, Section 2.3, an Active Staff Member must:
- (i) Contribute to the administration of the Medical Staff, including serving as a Medical Staff officer and on Hospital and Medical Staff committees as appointed or elected;
  - (ii) Participate in the performance improvement/quality assurance and utilization review activities required of the Medical Staff;
  - (iii) Discharge the recognized function of Staff membership by engaging in the Staff's teaching and continuing education programs, attending to charity patients as required, consulting with other Staff Members consistent with the Staff Member's scope of practice and delineated Privileges, supervising Practitioners during the provisional period, and fulfilling such other functions as may reasonably be required of Staff Members;
  - (iv) Attend at regular and professional meetings of the Medical Staff and of any Medical Staff committees of which the Active Staff Member is a member;
  - (v) Promptly pay all Medical Staff dues and assessments;

### 3.3 Courtesy Staff.

- (a) Qualifications: A Courtesy Staff Member must:
- (i) Reside or have a business office that is within sufficiently close proximity to the Hospital (as determined by the Medical Executive Committee) to enable the Courtesy Staff Member to provide continuous care to the Courtesy Staff Member's patients, or make arrangements that are satisfactory to the Chief of Staff for alternative Physician coverage for patients for whom the Courtesy Staff Member is responsible;
  - (ii) Be responsible and regularly involved with inpatient and outpatient services and procedures in any Medical Staff year.
  - (iii) Have treated, admitted, consulted on, performed procedures on or otherwise been involved in the care of such number of patients as the Board shall, after receiving the recommendations of the Medical Staff Executive Committee, determine from time to time to be reasonably required for the Physician to maintain clinical competence and familiarity with the operations of the Hospital and for the Hospital to be able to evaluate clinical competence and conduct of the Practitioner;
  - (iv) Demonstrate active participation in the active Medical Staff at another hospital requiring performance improvement/quality assurance activities similar to those at this Hospital, or agree to fulfill the responsibilities of Active Staff membership specified in Subsection 3.2(c) of this Article IV concerning participation in performance improvement/quality assurance and utilization review activities at this Hospital and participation in clinical programs and attendance at committee meetings; and
  - (v) Meet the requirements as provided in Article 2, Section 2.2. (b)

Prerogatives: A Courtesy Staff Member may:

- (i) Admit patients in the same manner as an Active Staff Member as provided in Subsection 3.2(b) of this Article 3 and may exercise such Clinical Privileges as are granted to the Courtesy Staff Member. At times of full Hospital occupancy or a shortage of hospital beds or other facilities, as determined by the Chief Executive Officer, the elective patient admissions of Courtesy Staff Members shall be subordinate to those of Active Staff Members;
- (ii) Not vote at Medical Staff meetings or hold office in the Medical Staff, except that Courtesy Staff Members may vote on any committees to which they are assigned, but shall not chair committees;
- (iii) Not be eligible to serve on the Executive Committee; and
- (iv) Attend regular and professional meetings of the Medical Staff. (c)

Obligations: A Courtesy Staff Member must:

- (i) Pay any dues or fees that may be assessed; and

- (ii) Meet the requirements as provided in Article 2, Section 2.3, and Article 3 Subsection 3.3(a).

3.4 Consulting Staff.

- (a) Qualifications: A Consulting Staff Member must meet the following criteria:
  - (i) Possess specialized skills needed at the Hospital for a specific project or, on an occasional basis, in consultation when requested by a Medical Staff Member;
  - (ii) Demonstrate active participation on the Active Medical Staff at another hospital requiring performance improvement/quality assurance activities similar to those of this Hospital, or agree to fulfill the obligation of Active Staff membership specified in Subsection 3.2(c) of this Article 3 concerning participation in performance improvement/quality assurance and utilization review activities at this Hospital and participation in clinical programs and attendance at committee meetings; and
  - (iii) Meet the requirements as provided in Article 2, Section 2.2. (b)

Prerogatives: A Consulting Staff Member may:

- (i) Perform services delineated in the Clinical Privileges granted to the Consulting Staff Member;
  - (ii) Examine patients and write consultation reports and orders for treatment or testing upon request of an Active or Courtesy Member of the Hospital;
  - (iii) Not admit patients to the Hospital, hold office on the Medical Staff or participate in any vote during meetings of the Medical Staff;
  - (iv) Serve on, but not chair, committees; and
  - (v) Attend regular and professional meetings of the Medical Staff, but may not vote.
- (c) Obligations: A Consulting Staff Member must: (i)
- Pay any dues or fees assessed; and
  - (ii) Meet the requirements as provided in Article 2, Section 2.3 and Section 3.4(a) of this Article 3.

3.5 Honorary Staff. Omitted.

3.6 Emergency Room Physicians.

- (a) Qualifications: The Hospital may, from time to time, enter into contracts with Physicians for the provision of services in the Emergency Room of the Hospital, and the Physicians providing such services shall be in the Staff category of Emergency Room Physician.

Article 2, Section 2.6 of these Bylaws, will govern a Physician covered by this Section 3.6. An Emergency Room Physician must:

- (i) Provide services to the Hospital under contract; and
- (ii) Meet the requirements as provided in Article 2, Section 2.2. (b)

Prerogatives: An Emergency Room Physician:

- (i) May exercise such Clinical Privileges as are granted to the Emergency Room Physician;
  - (ii) Has no right to admit patients to the Hospital independent of the necessity to admit a patient while performing services in the Emergency Room; and
  - (iii) Is not eligible to hold office in the Medical Staff or to vote at meetings of Medical Staff or committees.
- (c) Obligations: Each such Emergency Room Physician:
- (i) Must satisfy the basic obligations of Staff membership as described in Article 2, Section 2.3 of these Bylaws; and
  - (ii) Is encouraged to attend regular and special Staff meetings, and may be asked to serve on committees, but is not required to do so.

### 3.7 Telemedicine Practitioners.

- (a) Qualifications: The Hospital may, from time to time, enter into contracts with Practitioners or other organizations for the provision of services to Hospital patients via telemedicine. A Telemedicine Staff Member must:
- (i) Provide telemedicine services to the Hospital under a contract with the Hospital or through a third party contracted with the Hospital;
  - (ii) Demonstrate active participation on the Active Medical Staff at another hospital requiring performance improvement/quality assurance activities similar to those of this Hospital, or agree to fulfill the obligation of Active Staff membership specified in Subsection 3.2(c) of this Article 3 concerning participation in performance improvement/quality assurance and utilization review activities at this Hospital; and
  - (iii) Meet the requirements as provided in Article 2, Section 2.2. (b)

Prerogatives: A Telemedicine Practitioner:

- (i) May exercise such Clinical Privileges as are granted to the Telemedicine Practitioner;
- (ii) Has no right to admit patients to the Hospital; and

- (iii) Is not eligible to hold office in the Medical Staff or to vote at meetings of Medical Staff or committees.
- (c) Obligations: A Telemedicine Practitioner:
  - (i) Must meet the requirements of Article 2, Section 2.3; and
  - (ii) Is encouraged to attend regular and special Staff meetings and may be asked to serve on committees, but is not required to do so.

3.8 Locum tenens.

- (a) Qualifications: A *locum tenens* Physician is a Practitioner who has been hired by a member of the Medical Staff to provide coverage for defined periods of time and who has been granted temporary Privileges in accordance with Article 6, Section 6.10.
- (b) Prerogatives: *Locum tenens* members neither vote nor hold any office.
- (c) Obligations: *Locum tenens* Physicians are strongly encouraged to attend general meetings of the Medical Staff and may attend committee meetings, but are not required to do so.

3.09 Psychologists.

- (a) Qualifications: A Psychologist must meet the requirements as provided in Article 2, Section 2.2.
- (b) Prerogatives: Psychologists admitted to the Medical Staff:
  - (i) Shall have all rights, Privileges and responsibilities as set forth in the Section of this Article 3 applicable to the Psychologist's Staff category, except as hereinafter limited and as limited in Article 6, Section 6.8, of these Bylaws entitled "Special Conditions for Psychologists;" and
  - (ii) May admit patients directly to the Hospital subject to the limitations described in Subsection 3.09(b)(i) above and in this Subsection 3.09(b)(ii) of Article 3. Consultation with a qualified Physician who is a member of the Medical Staff shall be required for documentation of the same basic medical appraisal as for patients admitted for other services.  
Psychologists are responsible for documentation of the complete psychological history and physical examination. Patients for psychological care, whether admitted as inpatients or as outpatients, shall be under the care of a Physician Member of the Medical Staff. The Psychologist Staff Member must request appropriate consultation when unusual or non-psychological complications are encountered.
- (c) Obligations: Psychologist Members of the Medical Staff:
  - (i) Must meet the requirements of Article 2, Section 2.3.
  - (ii) Shall be responsible for the completion of records in the Psychologist's field, and shall record the psychological history, examination and a simple statement on the patient's general health; and

- (iii) May write orders within the scope of the Psychologist's license, as limited by applicable law, as consistent with Medical Staff Rules and Regulations and Hospital policies and procedures, and within the scope of the Psychologist's Privileges as granted pursuant to these Medical Staff Bylaws.

3.10 Podiatrists.

- (a) Qualifications: A Podiatrist must meet the requirements as provided in Article 2, Section 2.2.
- (b) Prerogatives: Podiatrists admitted to the Medical Staff:
  - (i) Shall have all rights, Privileges and responsibilities as set forth in the Section of this Article 3 applicable to the Podiatrist's Staff category, except as hereinafter limited and as limited in Article 6, Section 6.9, of these Bylaws entitled "Special Conditions for Podiatrists;" and
  - (ii) May admit patients directly to the Hospital subject to the limitations described in Subsection 3.10(b)(i) above and in this Subsection 3.10(b)(ii) of Article 3. Consultation with a qualified Physician who is a member of the Medical Staff shall be required for documentation of the same basic medical appraisal as for patients admitted for other services. Podiatrists are responsible for documentation of the complete podiatric history and podiatric physical examination. Patients for podiatric care, whether admitted as inpatients or as outpatients, shall be under the care of a Physician Member of the Medical Staff. The Podiatrist Staff Member must request appropriate consultation when unusual or non-podiatric complications are encountered.
- (c) Obligations: Podiatrist Members of the Medical Staff:
  - (i) Must meet the requirements of Article 2, Section 2.3.
  - (ii) Shall be responsible for the completion of records in the Podiatrist's field, and shall record the podiatric history, podiatric examination and a simple statement on the patient's general health; and
  - (iii) May write orders within the scope of the Podiatrist's license, as limited by applicable law, as consistent with Medical Staff Rules and Regulations and Hospital policies and procedures, and within the scope of the Podiatrist's Privileges as granted pursuant to these Medical Staff Bylaws.

3.11 Provisional Period. Scope:

- (a) All new Medical Staff appointments and all grants of initial or increased Clinical Privileges to any members are provisional for a period of up to one (1) year ("Provisional Period"). With respect to Applicants who are granted temporary Privileges during the pendency of their Application for Medical Staff membership and Privileges, the Provisional Period shall not run during the period of temporary Privileges, but shall begin at such time as the Applicant's Application is approved. During the Provisional Period, a provisional appointee's performance will be reviewed and evaluated by the Physician Coordinator, or the Physician Coordinator's designee, for the Service with which the Practitioner is primarily affiliated, and

by the Physician Coordinator of any other Service in which the Applicant has Privileges, or by any Active Staff Member specifically assigned the task by the applicable Physician Coordinator, and the Physician Coordinator shall certify successful completion of the Provisional Period.

- (b) No Effect on Membership or Exercise of Privileges: During the Provisional Period, a Practitioner must meet all qualifications, can exercise all of the Prerogatives, and must fulfill all of the obligations of the Practitioner's Staff category; and the Practitioner can utilize all of the Clinical Privileges granted to the Practitioner.
- (c) Review Requirements: The Executive Committee, subject to approval of the Board, shall establish requirements necessary for any review that is intended to conclude the Provisional Period. The provisional Practitioner must arrange for the number and type of cases required for review and observation by the relevant Physician Coordinator or other designated person within a time frame that results in the required cases being reviewed/observed before the end of the Provisional Period.
- (d) Procedure for Concluding or Extending the Provisional Period: Prior to the end of the Provisional Period, the Practitioner must submit to the Credentials Committee a request for declaration that all or any part of the Practitioner's Provisional Period has been successfully concluded or a request for an extension of the Provisional Period. A new appointee's request must be accompanied by one (1) or more signed statements described in Subsection 3.10(d)(i) and (ii) of this Article 3. The request of an existing Staff Member with respect to increased Privileges must be accompanied by one (1) or more signed statements described in Subsection 3.10(d)(ii) of this Article 3. The statements that must be furnished are as follows:
  - (i) From the Physician Coordinator of the Service in which the Practitioner's appointment was made attesting that by observed performance, the Practitioner has demonstrated the Practitioner's qualifications for Staff membership in the Practitioner's Staff category, that the Practitioner has not abused the Practitioner's Prerogatives, and that the Practitioner has discharged the Practitioner's membership obligations; and
  - (ii) From the Physician Coordinator of each Service in which the Practitioner was granted initial or increased Clinical Privileges, that the Practitioner has satisfactorily demonstrated the Practitioner's ability to exercise those Privileges.

Failure, without good cause, of a Practitioner to act to conclude or extend the Provisional Period is deemed a voluntary relinquishment of Medical Staff membership or the Clinical Privileges provisionally granted, or both, as applicable.

- (e) Procedure for Processing Request: Upon receipt of the request and statement(s) described in Subsection 3.10(d) of this Article 3, the Credentials Committee shall prepare and forward to the Medical Executive Committee a written report with recommendations and supporting documentation. Final processing shall follow the procedures set forth in the Application process as described in Article 5, Subsections 5.7(d) through (i). For purposes of concluding the Provisional Period, an "adverse recommendation" by the Medical Executive Committee or an "adverse action" by the Board shall be as defined in Article 7 of these Bylaws.
- (f) Extension: If an initial appointee or a Medical Staff Member is unable to obtain the statement(s) required by Subsection 3.11(d) above because of insufficient patient

contacts or because the Practitioner's caseload at the Hospital was inadequate to demonstrate ability to exercise the Privilege in question, the Practitioner may submit to the Credentials Committee a statement to this effect describing the Practitioner's caseload and signed by the Physician Coordinator of the applicable Service. Upon receipt of such statement, the Provisional Period for exercising the Privilege or Privileges involved shall be extended for a period not to exceed one (1) additional year unless the Medical Executive Committee or the Board, after receiving the report of the Credentials Committee, determines such extension is inappropriate.

- (g) Procedural Rights: Whenever any Provisional Period expires without favorable conclusion for the Practitioner, or whenever an initial or additional extension is denied, the Chief Executive Officer will provide the Practitioner with Special Notice of the adverse result and of the Practitioner's entitlement to the procedural rights provided in Article 12 of these Bylaws.

#### **ARTICLE 4 - ALLIED HEALTH PROFESSIONALS**

- 4.1 Nature of Health Professionals. An Allied Health Professional ("AHP") is an individual other than a licensed Practitioner who functions in a medical support role to a Practitioner or exercises independent judgment within the area of the AHP's professional competence and who is qualified by licensure, certification or other approval to render medical or surgical care under the supervision of a Practitioner who has been accorded Privileges to provide such care in the Hospital. The following professionals may be AHPs for the purposes of this Section 4.1: Advanced Practice Registered Nurses, Chiropractors, Nurse Anesthetists, Anesthesia Assistants, Optometrists, and Physician's Assistants. Individuals in this category are not members of the Medical Staff and shall have only such limited duties, responsibilities and Prerogatives as may be specifically set forth herein. AHPs will not be eligible to vote or hold office in the Medical Staff. AHPs may be invited to attend Medical Staff meetings. The Board shall specify by policy or regulation, the classes of AHP that may be granted Clinical Privileges in the Hospital. In establishing such classes, the Board shall consider such factors as needed in the Hospital for the types of services provided by the particular classes of AHP and the availability of Medical Staff Members appropriately trained to oversee the type of services provided by a particular class of AHP. Certain categories of AHP shall require Physician sponsors to perform any services in the Hospital. Guidelines for each AHP category shall set forth whether sponsorship is required, and the procedures for obtaining said sponsorship.

The Medical Staff Executive Committee may make a recommendation to the Board regarding the types of AHP to be granted Clinical Privileges in the Hospital, and the Board shall consider such recommendation prior to making its decision.

- 4.2 Qualifications. To be eligible for Clinical Privileges within the Hospital, an AHP must: (a) Be within an AHP category approved for Clinical Privileges by the Board;
- (b) Meet the personal qualifications specified in Article 2, Section 2.2 other than Subsections 2.2(a) and (b) thereof;
  - (c) Provide evidence of adequate education, training and experience with respect to the services provided and as determined by Board policy for each type of AHP;

- (d) Hold a license, certificate or such other credentials as may be required by applicable state law;
- (e) Provide proof of malpractice insurance in an amount required by the Board; and
- (f) Meet all other requirements imposed by the Board for the individual's category of AHP.

4.3 Prerogatives. An AHP's Prerogatives are to:

- (a) Provide specifically designated patient care services under the direct or ultimate (as determined by Board policy or regulation) supervision or direction of a Medical Staff Member;
- (b) Write orders only to the extent specified in the Medical Staff Rules and Regulations, Hospital policies, or the position description developed for that category of AHPs;
- (c) Exercise such other Prerogatives as the Medical Executive Committee, with the approval of the Board, grants any general or specific category of AHPs; and
- (d) Serve on Medical Staff committees when appointed. AHPs shall not have the privilege of voting or holding office in the Medical Staff. AHPs may, however, participate in committees and vote at committee meetings. An AHP may not independently admit patients. Each patient's general medical condition and care shall be the ultimate responsibility of a qualified Physician Member of the Medical Staff.

4.4 Obligations of AHPs. Each AHP shall:

- (a) Meet the basic responsibilities contained in Article 2, Section 2, designed for Medical Staff Members;
- (b) Assume responsibility to the extent applicable under the AHP's scope of practice for the care and supervision of each patient in the Hospital for whom the AHP is providing services;
- (c) Participate as requested in performance improvement/quality assurance program activities and in discharging related performance improvement/quality assurance duties as may be required from time to time;
- (d) Attend clinical and educational meetings of the Hospital and/or Medical Staff as requested as well as meetings of committees of which the AHP is a member; and
- (e) Refrain from any actions that are or may be reasonably interpreted as being beyond, or an attempt to exceed, the AHP's scope of practice under state law and as authorized by the Hospital.

4.5 Application for Privileges. Every AHP who seeks or enjoys Clinical Privileges must make written Application for such Privileges or for any increase in Privileges. Applications for appointment or reappointment of Clinical Privileges of AHPs shall be processed in accordance with the procedures established by the Medical Executive Committee and approved by the Board. Included in the Application shall be the name of the Medical Staff Member who will remain the sponsor of the Applicant until a change of sponsor is granted. The Applicant or the

Applicant's sponsor shall submit a written statement of the clinical duties and responsibilities for which the Applicant is requesting Clinical Privileges. The Applicant shall agree to abide by these Bylaws to the extent they are applicable to AHPs and other Medical Staff and Hospital Bylaws, Rules, Regulations, policies and procedures (including, but not limited to, Hospital's Corporate Compliance Plan).

4.6 Procedure for Specification of Services. Written guidelines for specified services that may be provided by each category of AHP will be developed by the Credentials Committee, subject to approval by the Medical Executive Committee and the Board and with input, as applicable, from the Physician Coordinator of the Clinical Service involved, the AHP's sponsor, and, as appropriate, other Representatives or groups of the Medical Staff and Hospital administration. For each category of AHP, such guidelines must include at least:

- (a) Minimum requirements for prior training and experience;
- (b) Specification of the types of patients that may be seen;
- (c) A description of services and procedures to be provided, including any special equipment, procedures or protocol that may be required, and the requirements for recording of Services provided in the patient's medical record;
- (d) Definition of the degree of assistance that an AHP may require from a Medical Staff Member (including the degree of Staff Supervision required for each Service) in the treating of patients on Hospital premises and any limitations applicable to each service; and
- (e) Whether the category of AHP shall require sponsorship and, if so, procedure(s) for the designation of said sponsor.

4.7 Service Assignment. An AHP shall be individually assigned, when appropriate, to the Service appropriate to the AHP's professional training, and shall be subject to an initial probationary period, formal periodic reviews and disciplinary procedures as determined for the AHP's category.

4.8 Review of Credentials. AHP's credentials shall be reviewed on at least an annual basis the first two (2) years of the AHP's appointment and at least every two (2) years thereafter.

4.9 Procedural Rights. An AHP is not eligible for the procedural due process rights as provided for Medical Staff Members in Article 12 of these Bylaws unless otherwise determined by the Board for the AHP's specific category of AHP. The Board shall determine, consistent with applicable law, what procedural due process rights (and commensurate reporting requirements) shall apply to any category of AHP. The Board shall establish a policy and procedure delineating criteria for and specific rights to fair hearing and appeal procedures for AHPs.

## **ARTICLE 5 - APPLICATION, APPOINTMENT AND REAPPOINTMENT PROCEDURES**

5.1 General. Unless otherwise provided for herein, no person shall exercise Clinical Privileges in the Hospital unless and until the person applies for and receives Medical Staff appointment and/or such Privileges are granted, as set forth in these Bylaws. Appointment to Medical Staff shall confer only those specific Clinical Privileges as have been granted in accordance with these Bylaws.

- 5.2 Pre-Application. An Applicant desiring appointment to the Medical Staff shall obtain a pre-Application for Medical Staff appointment form from the Chief Executive Officer of the Hospital, complete the pre-Application form in full and return it to the Chief Executive Officer. The specific contents of the pre-Application form shall be as determined by the Board after consultation with the Executive Committee of the Medical Staff and shall be set forth in the Medical Staff Rules and Regulations. Generally, the form shall require information regarding medical or dental school completion; for Physicians and other Staff Members as applicable, residency training as well as verification of an unrestricted license to practice medicine in the State of Oklahoma and DEA registration, if applicable. The pre-Application form also shall request that the pre-Applicant indicate generally the Privileges for which the pre-Applicant will be applying. The Chief Executive Officer and the Chief of Staff will review completed pre-Application forms to determine whether the Applicant shall be issued an Application for Medical Staff appointment. When reviewing the completed pre-Application forms, the Chief Executive Officer and the Chief of Staff shall consider whether the pre-Applicant has the requisite training and licensure, whether the Hospital has a need for the type of services the pre-Applicant proposes to perform, and the appropriate facilities and support personnel for the Privileges to be requested. If the pre-Applicant receives an Application for Medical Staff appointment, the Chief Executive Officer shall, in addition to supplying the Application form, supply the Applicant with a copy of the Hospital Bylaws the Hospital Corporate Compliance Plan, and the Bylaws, and Rules and Regulations of the Medical Staff. The Chief Executive Officer also shall provide to the Applicant a brief orientation to the Medical Staff Bylaws, including a description of the mechanism for appointment and reappointment, in such format as determined by the Medical Executive Committee and approved by the Board.
- 5.3 Application. A written, signed Application for Medical Staff appointment must be submitted to the Chief Executive Officer on the Application form approved by the Board.
- 5.4 Application Contents. Every Application must include at least the following:
- (a) A statement that the Applicant has been offered and/or received and read the Hospital Bylaws, the Medical Staff Bylaws and the Medical Staff Rules and Regulations, and the Hospital Corporate Compliance Plan; that the Applicant agrees to be bound by the terms thereof if the Applicant is granted membership and/or Clinical Privileges; and that the Applicant agrees to be bound by the terms thereof in all matters relating to consideration of the Applicant's Application without regard to whether the Applicant is granted membership or Clinical Privileges.
  - (b) Any post-secondary school training, including the name of the institutions and the dates attended, any degrees granted, course of study or program completed, and for all post-graduate training, names of persons responsible for reviewing the Applicant's performance.
  - (c) A copy of all currently valid professional licenses or certifications, DEA registration, and any other controlled substances registration, including the date of issuance and license or provider number.
  - (d) Records verifying any specialty or subspecialty board certification, recertification, or eligibility to sit for such board's examination.

- (e) A statement as to whether the Applicant's health status is such that the Applicant is able to perform all the procedures for which the Applicant has requested Privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients. If the Applicant will require reasonable accommodation, the Application should include a separate sheet to describe the accommodation(s) that will enable the Applicant to perform the clinical activities for which the Applicant has requested Privileges.
- (f) Documentation verifying professional liability coverage, including the names of present and past insurance carriers, and any information related to Practitioner's malpractice claims history and experience during the past five (5) years.
- (g) The nature and specifics of any prior actions involving denial, revocation, non-renewal or other challenges or voluntary relinquishment (by resignation or expiration) of any professional license or certificate to practice in Oklahoma or in any other state or country; any controlled substances registration; membership or fellowship in local, state or national organizations; specialty or sub-specialty board certification or eligibility; faculty membership at any medical or other professional school; Medical Staff membership, Prerogatives or Clinical Privileges at any other health care institution, including any hospital, clinic, skilled nursing facility or managed care organization in this or any other state; participation in a federal or state health care program; or professional liability insurance.
- (h) Location of the Applicant's office(s); names and addresses of other Practitioners with whom the Applicant is or has been associated and the dates of the associations; names and locations of all health care institutions or organizations (including third-party payors) with which the Applicant had or has any association, employment, Privileges or practice and the dates of each affiliation; and status held, general scope of Clinical Privileges or duties and documentation of conformity with applicable Hospital and Medical Staff Bylaws, Rules and Regulations at such other institutions where the Applicant had Privileges.
- (i) The Medical Staff category, Clinical Service assignment and Clinical Privileges requested.
- (j) The status and, if applicable, resolution of any past or current criminal charges against the Applicant.
- (k) The names of at least three (3) medical or health care professionals in the Applicant's same profession or a member of the local county or regional medical society (for use as professional references) who have known the Applicant for a minimum of two (2) years and who, through observation, have personal knowledge of the Applicant's Clinical ability, ethical character, the effect of the Applicant's health status, if any, on the Privileges sought, ability to work cooperatively with others, and who are willing to provide specific written comments on these matters upon request from the Medical Staff or Hospital. At least one (1) of such individuals must have had organizational responsibility for supervision of the Applicant's performance.
- (l) A listing and description of any potential conflict(s) of interest with the Hospital or its related entities (including any ownership or contractual interest the Applicant or the

Applicant's immediate family members might have with the Hospital or with entities that do business with the Hospital).

- (m) Such other information as the Board [Trustees] may require, subject to existing legal requirements.
- (n) The Applicant's signature.

5.5 Effect of Application. By signing and submitting an Application for appointment to the Medical Staff, the Applicant:

- (a) Acknowledges and attests that the Application is correct and complete, and acknowledges that any significant misstatement or omission is grounds for a denial of appointment or for a summary dismissal from the Medical Staff.
- (b) Agrees to appear for personal interviews, if required, in support of the Application.
- (c) Consents to the release and review by Hospital Representatives of all documents (including requesting and reviewing information from the National Practitioner Data Bank and any other data bank the Hospital is permitted or required by law to access) that may be necessary to evaluate the Applicant's professional qualifications and ability to carry out the Clinical Privileges the Applicant requests as well as the Applicant's professional ethical qualifications for Staff membership and consents to Hospital Representatives consulting with prior associates or others who may have information bearing on the Applicant's professional or ethical qualifications and competence.
- (d) Understands and agrees that if Medical Staff membership or requested Clinical Privileges are denied based on the Applicant's professional competence or conduct, the Applicant will be subject to reporting to the National Practitioner Data Bank.
- (e) Releases from any liability all Hospital Representatives for their acts performed in good faith and without malice in connection with reviewing, evaluating or acting on the Application and the Applicant's credentials.
- (f) Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital Representatives in good faith and without malice concerning the Applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications necessary for appointment as discussed herein.
- (g) Agrees that any lawsuit brought by the Applicant against an individual or organization providing information to a Hospital Representative, or against the Hospital or Hospital Representative, shall be brought in a court, federal or state, in the state in which the defendant resides or is located.
- (h) Agrees to practice in an ethical manner and to provide continuous care to patients. (i)

Agrees to notify the Chief of Staff and the Chief Executive Officer immediately if

any information contained in the Application changes. The foregoing obligation shall be a continuing obligation of the Applicant so long as the Applicant is a member of the Medical Staff and/or has Clinical Privileges at the Hospital.

- (j) Agrees to be bound by the terms of and to comply in all respects with these Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, policies and procedures, and Hospital's Corporate Compliance Plan.

5.6 Burden of Providing Information. The Applicant is responsible for producing information adequate to properly evaluate the Applicant's experience, background, training, demonstrated competence, utilization patterns, work habits (which include the ability to work cooperatively with others), and, upon request of the Executive Committee, Chief Executive Officer or Chief Executive Officer's designee, or the Board, physical and mental health status, and to resolve any doubts or conflicts and to clarify information as requested by appropriate Staff or Board authorities.

5.7 Processing Application.

- (a) The completed Application shall be submitted to the Chief Executive Officer who shall immediately forward the same to the Credentials Committee for processing. The Credentials Committee or its designee shall be responsible for collecting and verifying all qualification information received, and for promptly notifying the Applicant of any problems with obtaining required information. Upon notification of any problems or concerns, the Applicant must obtain and furnish the required information. If the Applicant fails to furnish the requested information within ninety (90) days of a written request, the Application shall be finally and conclusively deemed denied without right to a hearing or appellate review, and the Applicant shall be so informed by the Chief Executive Officer. The Credentials Committee or its designee shall query the National Practitioner Data Bank and any other data bank as permitted or required by law. The Credentials Committee or its designee also shall check the U.S. Department of Health and Human Services Office of Inspector General Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the Applicant has been convicted of a health care related offense, or debarred, excluded or otherwise made ineligible for participation in federal health care programs. When the collection and verification process is accomplished, the Credentials Committee shall transmit the Application and all supporting materials to the Physician Coordinator(s) of each Clinical Service in which the Applicant seeks Privileges.
- (b) The Physician Coordinator (or the Physician Coordinator's designee) of each Clinical Service in which the Applicant seeks Privileges is responsible for reviewing the Application and any supporting documentation, and shall prepare a written report evaluating the evidence of the Applicant's training, experience and demonstrated ability and stating how the Applicant's skills are expected to contribute to the clinical and educational activities of the Service. This report should be forwarded to the Credentials Committee and must state the Physician Coordinator's recommendation as to approval or denial of, and any special limitations on, Medical Staff appointment, category of Medical Staff membership and Prerogatives, Clinical Service affiliation. and Staff Clinical Privileges. Before submitting a report to the Credentials Committee, the Physician Coordinator may, at the Physician Coordinator's discretion, conduct an interview with the Applicant.

- (c) After receipt of the Physician Coordinator’s report, the Credentials Committee is responsible for reviewing the report, all Application materials and any other relevant information available to it. The Credentials Committee is then responsible for preparing and submitting a written report and recommendations to the Medical Executive Committee as to approval or denial of, and any special limitations on, Medical Staff appointment, category of Medical Staff membership and Prerogatives, Service affiliation, and Clinical Privileges.
- (d) After receipt of the Credentials Committee report, the Medical Executive Committee, at its next regularly scheduled meeting, shall review the Application, the supporting documentation, the reports and recommendations from the Physician Coordinator(s) and Credentials Committee, and any other relevant information available to it. The Medical Executive Committee shall vote on the Application and take one of the actions described in 5.7(e).
- (e) The Medical Executive Committee may take any of the following actions:
  - (i) Deferral Action. A decision by the Medical Executive Committee to defer any action on the Application must be revisited, except for good cause, within thirty (30) days with subsequent recommendations as to approval or denial of, or any special limitations on, Medical Staff Appointment, category of Medical Staff membership and Prerogatives, Service affiliation, scope of Clinical Privileges, and length of Provisional Period. The Chief Executive Officer of the Hospital shall promptly send the Applicant written notice of a decision to defer action on the Applicant's Application.
  - (ii) Favorable Recommendation. If the Medical Executive Committee makes a favorable recommendation regarding all aspects of the Application, the Medical Executive Committee shall promptly forward its recommendation, together with all supporting documentation, to the Board.
  - (iii) Adverse Recommendation. If the Medical Executive Committee’s recommendation is adverse to the Applicant, the Medical Executive Committee must immediately inform the Applicant by Special Notice of the recommendation, and the Applicant shall then be entitled to the procedural rights as provided in Article 12. No such adverse recommendation shall be required to be forwarded to the Board until after the Applicant has exercised or has been deemed to have waived the Applicant's right to a hearing as provided in Article 12 of these Bylaws.
- (f) The Board may take any of the following actions:
  - (i) Favorable Medical Executive Committee Recommendation. The Board may adopt or reject any portion of the Medical Executive Committee’s recommendation that was favorable to an Applicant or refer the recommendation back to the Medical Executive Committee for additional consideration, but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation must be made. If the Board’s action is favorable, the action shall be effective as its final decision. If the Board decision on receiving a favorable Medical Executive Committee recommendation is adverse to the Applicant, the Board shall so notify the Applicant by Special Notice, and the Applicant shall be entitled to the procedural rights provided in Article 12 of these Bylaws.
  - (ii) Without Benefit of Medical Executive Committee Recommendation. If the Medical Executive Committee fails to make a recommendation within the time required, the

Board may, after informing the Medical Executive Committee of its intent, and allowing a reasonable period of time for response by the Medical Executive Committee, make its own determination using the same type of criteria considered by the Medical Executive Committee. If the Board's decision is adverse to the Applicant, the Board shall promptly so inform the Applicant by Special Notice, and the Applicant shall then be entitled to the procedural rights provided in Article 12 of these Bylaws.

- (iii) Adverse Medical Executive Committee Recommendation. If, after adverse recommendation by the Medical Executive Committee, the Practitioner waives rights to a hearing under Article 12 of these Bylaws, the recommendation will be submitted to the Board for final determination. If the Practitioner requests a hearing under Article 12 in response to the adverse recommendation of the Medical Executive Committee, then the Board will review and finalize its determination consistent with the fair hearing and appellate process described in Article 12.
- (g) Any report by an individual or group, including the report of the Board, required by any portion of this Section 5.7, must state the reasons for each recommendation or action taken, with specific reference to appropriate portions of the Application or other documentation. The reasons shall relate to, but not be limited to, standards of patient care, patient welfare, the objectives of the Hospital, or the conduct or competency of the Applicant. Any dissenting views at any point in the process also must be evidenced in writing, supported by reasons and references, and transmitted with the majority report.
- (h) The Board shall give notice of its final decision to the Applicant by Special Notice and to the Chief of Staff. The Chief of Staff shall, in turn, transmit the decision to the Physician Coordinator of each Clinical Service concerned. A decision and notice to appoint shall include: the Medical Staff category to which the Applicant is appointed; the Clinical Service to which the Applicant is assigned; the Clinical Privileges the Applicant may exercise; the length of the provisional period and any special conditions attached to the Appointment.
- (i) With respect to initial Staff appointments, granting of Staff membership and Clinical Privileges shall be contingent upon review and ascertainment of adequate health status. Upon notification of such contingent appointment, the Applicant shall submit to the Medical Executive Committee the following information: any previous or current health problem or disability (including alcohol or drug dependencies) that affects or that may be expected to progress within the next two (2) years to the point of affecting the Applicant's ability in terms of skill, attitude or judgment to perform professional and Medical Staff duties fully; hospitalizations or other institutionalizations for any such health problem or disability during the past ten (10) year period; if any such health problem or disability in the past is currently controlled by therapy or is resolved but may reoccur, date of last health examination with name and address of performing Physician and findings related to that problem or disability. Any such information shall be maintained in a separate file as a confidential medical record. The Medical Executive Committee will review such information to determine whether the Applicant's health status is such that the Applicant will be able to perform the procedures for which the Applicant has requested Privileges, with or without accommodation, according to accepted standards of professional performance and without posing a direct threat to patients. The Medical Executive Committee shall then make a recommendation to the Board as to whether the contingent offer of membership should be made final.

Such recommendation and subsequent Board action shall be in accordance with Subsections 5.7(e) and (f) of this Article 5.

- (j) All individuals and groups required to act on an Application under this Section 5.7 must do so in good faith and, except for good cause, complete their actions within the following time period:

<u>Individual/Group</u>	<u>Time</u>
Credentials Committee (collection/verification)	sixty (60) days
Department Director [Physician Coordinator]	thirty (30) days
Credentials Committee	thirty (30) days
Medical Executive Committee	Next regular meeting
Board of Trustees [Trustees]	Next regular meeting

These time periods are considered guidelines and do not create any rights for a Practitioner to have an Application processed within these precise periods; provided, however, that this provision shall not apply to the time periods contained in the provisions of Article 12. When Article 12 is activated by an adverse recommendation or action as provided herein, the time requirements set forth therein shall govern the continued processing of the Application.

- (k) An Applicant who has received a final adverse decision regarding, or who has voluntarily resigned or withdrawn an Application for, appointment, reappointment, Medical Staff category, Clinical Service assignment, or Clinical Privileges may not reapply to the Medical Staff or for the denied Medical Staff category, Clinical Service, or Clinical Privileges for a period of at least one (1) year. Any reapplication after the one (1)-year period will be processed as an initial Application, and the Applicant must submit such additional information as required by the Medical Staff or the Board to show that any basis for the earlier adverse action has been resolved.
- (l) If an Applicant's file remains incomplete ninety (90) days after the initial Application for membership, the Applicant will be deemed to have withdrawn the Applicant's Application for membership. The Chief Executive Officer shall notify that Applicant that the Applicant's Application is considered to have been withdrawn, and that the Applicant shall not be entitled to a hearing or any other procedural rights with respect to such Application.

5.8 Reappointment.

- (a) No later than three (3) months prior to the date of expiration of the Medical Staff Member's appointment, the Chief Executive Officer shall cause the Medical Staff Member to be notified of the upcoming expiration date. No later than sixty (60) days before the expiration date, the Staff Member must furnish to the Credentials Committee the following reappointment materials in writing and on a form approved by the Board:
  - (i) All information necessary to bring the Applicant's file current regarding the information required by Section 5.4 of Article 5, including all current licensure and Board certification information, controlled substance registration,

professional liability insurance coverage, the status of other institutional affiliations, pending or completed disciplinary actions, and health status changes;

- (ii) A record of continuing medical and/or professional training and education completed outside of the Hospital during the preceding period;
- (iii) Any requests for additional or reduced Clinical Privileges, with the basis for any requested changes; and
- (iv) Any requests for Staff category or Service assignment changes, with the basis for the requested changes.

If a Staff Member without good cause fails to provide this information, the Staff Member will be deemed to have voluntarily resigned from the Staff and shall have the Staff Member's membership terminated automatically at the end of the current term unless the Staff Member requests, in writing, an extension and the extension is granted by the Medical Executive Committee for a period not to exceed forty-five (45) days. The Practitioner whose membership is so terminated is entitled to the procedural rights provided in Article 12 for the sole purpose of determining the issue of good cause.

The Credentials Committee shall verify the information provided on the reappointment Application and notify the Staff Member of any deficiencies, inadequacies or verification problems. The Staff Member then has the burden of producing adequate information and resolving any doubts about the data.

- (b) The Credentials Committee or its designee shall retain all relevant information regarding the Applicant's professional and collegial activity, performance, and conduct in the Hospital for inclusion in each Staff Member's credentials file. Such information shall include, but is not limited to, the following:

- (i) Findings of quality assessment and utilization review activities demonstrating patterns of patient care and utilization;
- (ii) Continuing education activities and participation in other internal training; (iii)

Clinical activity at the Hospital;

- (iv) Previously successful or currently pending challenges to the Staff Member's licensure, sanctions imposed or pending, and other problems related to the Staff Member's practice or professional conduct;
- (v) Health status, including any reasonable evidence of current health status that may be requested by the Medical Executive Committee (retained in a separate file as a confidential medical record);
- (vi) Records of attendance at required Medical Staff and Hospital meetings; (vii)

Performance as a Staff officer, committee member or chairperson;

- (viii) Participation in emergency room coverage;

- (ix) Compliance with requirements related to the preparation of medical records (including requirements regarding timeliness, completeness and accuracy);
- (x) Ability to work cooperatively with other Practitioners, Hospital personnel and the Board;
- (xi) General character of relationship with patients and the Hospital;
- (xii) Ability to comply with all applicable Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, policies and procedures, and Hospital's Compliance Plan;
  - (xiii) Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of Clinical Privileges at another hospital;
  - (xiv) Ability to practice in an efficient manner, taking into account the patients' medical needs, the facilities, services and resources available and generally recognized utilization standards as identified by the Utilization Review Committee; and
  - (xv) Any other relevant information that could affect the Staff Member's status and Privileges at Hospital, including any activities of Staff Member at other hospitals and Staff Member's clinical practice outside the Hospital.

When correction or verification is accomplished, the Credentials Committee shall cause the reapplication form and supporting materials to be forwarded to the Physician Coordinator(s) of the Service(s) in which the Staff Member requests Privileges.

- (c) The Physician Coordinator (or designee) of each Service in which a Staff Member has Privileges or has requested Privileges must evaluate the information contained in the Staff Member's file to assess the Applicant's continuing satisfaction of the qualifications contained in these Bylaws, and whether the requested Staff category, Clinical Service and Clinical Privileges are appropriate. Each applicable Physician Coordinator (or designee) shall send to the Medical Executive Committee a written report regarding the Staff Member's professional performance, judgment, and clinical and/or technical skills. This evaluation should be based on the Staff Member's data from organization performance improvement activities and can include procedures performed and their outcomes and can be based on pertinent results of review of operative and other procedures, medication usage, blood usage, medical records mortality rates, utilization management, meeting and committee attendance and risk management data. Any such criteria should be uniformly applied and documented in the credential files. The written report shall include recommendations for, and any special limitations on, reappointment or non-reappointment and Staff Category, Service and Clinical Privileges.
- (d) After receipt of the Physician Coordinator(s) report, the Credentials Committee is responsible for examining the Staff Member's file, the Physician Coordinator reports and all other relevant information available to it, and shall forward a written report to the Medical Executive Committee that contains recommendations for reappointment or non-reappointment and Staff Category, Service assignment and Clinical Privileges, including any limitations or restrictions.

- (e) The Medical Executive Committee shall review the Staff Member's file, the Physician Coordinator(s) and Credentials Committee reports, and any other relevant information available to it, and shall defer action on the reappointment or prepare a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and Staff category, Service assignment, Clinical Privileges and, if new Privileges or Staff category are requested, length of the Provisional Period.
- (f) The final determinations regarding reappointment Applications shall follow the process set forth in Subsections 5.7(e) through (h) of Article 5. For purposes of reappointment, the terms "Applicant" and "Appointment" as used in those Sections shall be read, as "Staff Member" and "Reappointment," respectively.
- (g) Notice provided to a Staff Member and the Staff Member's provision of updated information shall follow the procedure included in Subsection 5.8(a) of this Article 5. Thereafter, and except for good cause, any other party who is obligated to act under these Bylaws must forward reappointment reports and recommendations to the Medical Executive Committee, and all such reports and recommendations must be returned to the Board before the expiration of the Staff membership of the renewal Applicant.

The time periods addressed are guidelines for accomplishing the reapplication process. If this process has not been completed due to Hospital's delay by the end of the membership or appointment term, the Staff Member remains a current member and keeps the Staff Member's Clinical Privileges until the time that the process is complete, unless corrective action is taken. If the delay is due to the Staff Member's failure to provide information included in Subsection 5.8(a) of this Article 5, the Staff Member's Staff membership ends on the expiration date as provided in said Subsection 5.8(a) of Article 5 unless explicitly extended as provided therein. Any extension of the process is not intended to (and shall not) create a right of automatic reappointment for the current term.

- (h) The Staff Member may, either in connection with reappointment or at any other time, request modification of the Staff Member's Staff category, Service assignment or Clinical Privileges by submitting a written Application to the Chief Executive Officer on the prescribed form. A modification Application is processed in the same manner as an Application for reappointment.

#### 5.9 Telemedicine Applications.

- (a) Where a Practitioner is requesting admission or readmission as a Telemedicine Practitioner on the Medical Staff, the Practitioner may be credentialed in accordance with the other sections of this Article 5, or, at Hospital's discretion, Hospital may rely upon credentialing information (including any supporting documentation required by Hospital) supporting and evidencing the Practitioner's current active Medical Staff membership at the "distant-site hospital" consistent with this Section 5.9.
- (b) If the Hospital chooses to rely upon the credentialing information of another accredited hospital, the Hospital Board and Medical Staff must ensure through a written agreement with the distant-site hospital that at least the following provisions have been met:

- (i) The distant-site hospital's governing body assumes the responsibility for ensuring the requirements of the Medicare Conditions of Participation for oversight of Medical Staff are satisfied;
  - (ii) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital and is a Joint Commission accredited facility
  - (iii) The individual distant-site Practitioner is privileged at the distant-site hospital providing the telemedicine services, and a current list of the distant-site Practitioner's Privileges are provided to Hospital;
  - (iv) The individual distant-site Practitioner holds a license issued or recognized by the State of Oklahoma; and
  - (v) For a distant-site Practitioner who holds current Privileges at the Hospital, the Hospital has evidence of an internal review of the distant-site Practitioner's performance of these Privileges and sends such performance information to distant-site hospital for use in the periodic appraisal of the distant-site Practitioner. At minimum, this information must include all adverse events (including sentinel events considered reviewable by The Joint Commission) that result from the telemedicine services provided by the distant-site Practitioner and all complaints the Hospital has received about the distant-site Practitioner.
- (c) If the distant-site entity is not a hospital facility, the Board and Medical Staff must ensure, through written agreement with the distant-site telemedicine entity, that all of the following provisions are met:
- (i) The distant-site telemedicine entity is a contractor of services to the Hospital and must furnish contracted services in a manner that permits the Hospital to comply with all applicable Medicare Conditions of Participation for the contracted services;
  - (ii) The distant-site telemedicine entity's governing body assumes the responsibility for ensuring that the distant-site telemedicine entity's medical staff credentialing processes and standards at least meet Medicare standards for hospital governing body oversight of Medical Staff;
  - (iii) The distant-site telemedicine entity's Medical Staff credentialing processes and standards at least meet Medicare standards for eligibility and process for appointment to Medical Staff; and
  - (iv) All requirements in Subsection 6.11(a)(iii) through (v) above are satisfied.
- (d) When the Hospital has decided that the Medical Staff may rely on the decisions of a distant-site hospital or distant-site telemedicine entity, the Application process described in 5.3 is replaced by the application process of the distant-site hospital or distant-site telemedicine entity.
- (e) The Medical Executive Committee must make a recommendation to the Board regarding the appointment or reappointment of each Telemedicine Practitioner and must document whether such recommendation is based on i) its own review of a Telemedicine Practitioner under Section 5.7(b)-(e) for appointments or Section 5.8(c)-

(e) for reappointments or ii) the decisions of a Hospital approved distant-site hospital or distant-site telemedicine entity.

## ARTICLE 6 - THE DELINEATION OF CLINICAL PRIVILEGES

- 6.1 Exercise of Privileges. Medical Staff appointment or reappointment shall not confer any Clinical Privileges or right to practice at the Hospital. Each individual who has been given an appointment to the Medical Staff or who otherwise provides Clinical Services at the Hospital may only exercise the Clinical Privileges specifically granted by the Board or temporary Privileges granted in accordance with Section 6.10 of this Article 6. Regardless of the level of Privileges granted, each Practitioner must consult with other Practitioners as required by the Medical Staff Rules and Regulations, other policies of the Medical Staff, any Clinical Services, or the Hospital.
- 6.2 Basis for Privileges Determination. Clinical Privileges recommended to the Board shall be based upon information submitted by Practitioner in accordance with these Bylaws and the criteria identified in Article 2, Section 2.2. In determining the Clinical Privileges to be recommended, consideration must, at minimum, be given to: (1) challenges to any licensure or registration; (2) voluntary or involuntary relinquishment of a license or registration, Medical Staff membership, or limitation, reduction or loss of Clinical Privileges; (3) any evidence of an unusual pattern or excessive number of professional liability actions resulting in final judgment against the Applicant; (4) documentation of the Applicant's health status; (5) relevant Practitioner-specific data as compared to aggregate data, when available; and (6) morbidity and mortality data, when available. The following additional factors also may be used in determining Privileges: patient care needs in the area for the type of Privileges requested by the Applicant; the geographic location of the Practitioner; coverage available in the Practitioner's absence; and the adequacy of professional liability insurance. If necessary, review of patient records treated in other hospitals or practice settings may affect Privileges determinations. Privileges determinations for current Staff Members seeking reappointment or a change in Privileges must include observed clinical performance and documented results of Staff quality assessment and utilization review activities, including, but not limited to, the appropriateness of admission and length of stay, necessity of procedures, and indication for ancillary services.
- 6.3 Service Responsibility in Defining Privileges. Each Service shall assist in defining and recommending in writing the Clinical Privileges for that Service, including the operative, invasive and any special procedures, conditions and problems that fall within its clinical area, including the various levels of severity or complexity and different patient profiles when appropriate, and the requisite training, experience or other qualifications required to perform the procedures or otherwise exercise the Clinical Privileges. The recommendations must be coordinated by the Credentials Committee and approved by the Medical Executive Committee and Board, must be reviewed and revised on at least a(n) annual basis, and shall form the basis for delineating Privileges within the Service. When the delineation of Clinical Privileges is revised, by additions or deletions, all Staff Members holding Clinical Privileges in the Service shall request and be processed for any added Clinical Privileges, or adjust their practices to comply with any resulting reduction in Clinical Privileges.
- 6.4 Consultation and Other Conditions. Special requirements for consultation may be required of Practitioners as a condition to the performance of any or all Clinical Privileges, in addition to the consultation requirements in the Bylaws or in the Rules, Regulations and Policies of the Staff, any Service, or Hospital. Each Practitioner requesting Clinical Privileges agrees that in dealing with cases outside the scope of the Practitioner's training or in an unusual area of practice, the Practitioner will seek appropriate consultation with a Practitioner who has expertise in such cases and, if necessary, refer such case to the Practitioner.

- 6.5 Requests. An Application for appointment and reappointment to the Medical Staff must contain a written request for all Clinical Privileges sought by the Applicant or Staff Member. Requests for temporary Privileges and modifications of Privileges in the interim between reappointment also must be submitted in accordance with the procedures contained in these Bylaws.
- 6.6 Procedure. Requests for Clinical Privileges shall be processed in accordance with the procedures outlined in Article 5 of these Bylaws, as applicable. Temporary Privileges requests shall be processed according to Section 6.12 of this Article 6.
- 6.7 Special Conditions for Dentists. Clinical Privileges requests received from Dentists shall be reviewed in accordance with the procedures contained in this Article VII. Surgical procedures shall be reviewed and supervised by the Surgery Department Director. Patients of Dentists must receive a basic medical evaluation by a Physician Member of the Medical Staff. A Physician Member of the Medical Staff also shall be responsible for the medical care of any patient during the patient's hospitalization and will advise on the risk and effect of any procedure on the patient's total health status. The Physician consultant and the Dentist must agree on the performance of any surgical procedure if a significant medical abnormality is present. The Surgery Department Director [Physician Liaison] will decide the issue in case of dispute. The Dentist is responsible for the dental history and physical and all appropriate elements of the patient's record. A Dentist specialist may write orders within the scope of the Dentist specialist's license as limited by law and as consistent with the Medical Staff Rules and Regulations. The Dentist specialist shall agree to comply with all applicable Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, and policies and procedures.
- 6.8 Special Conditions for Psychologists. Clinical Privileges requests received from Psychologists shall be reviewed in accordance with the procedures contained in this Article 6. Patients of Psychologists must receive a basic medical evaluation by a Physician Member of the Medical Staff. A Physician Member of the Medical Staff also shall be responsible for the medical care of any patient during the patient's hospitalization and will advise on the risk and effect of any procedure on the patient's total health status. The Psychologist is responsible for the psychological history and physical and all appropriate elements of the patient's record. A Psychologist may write orders within the scope of the Psychologist's license as limited by law and as consistent with the Medical Staff Rules and Regulations. The Psychologist shall agree to comply with all applicable Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, and policies and procedures.
- 6.9 Special Conditions for Podiatrists. Clinical Privileges requests received from Podiatrists shall be reviewed in accordance with the procedures contained in this Article 6. Surgical procedures shall be reviewed and supervised by the Surgery Physician Coordinator. Patients of Podiatrists must receive a basic medical evaluation by a Physician Member of the Medical Staff. A Physician Member of the Medical Staff also shall be responsible for the medical care of any patient during the patient's hospitalization and will advise on the risk and effect of any procedure on the patient's total health status. The Physician consultant and the Podiatrist must agree on the performance of any surgical procedure if a significant medical abnormality is present. The Surgery Physician Coordinator will decide the issue in case of dispute. The Podiatrist is responsible for the podiatric history and physical and all appropriate elements of the patient's record. A Podiatrist may write orders within the scope of the Podiatrist's license as limited by law and as consistent with the Medical Staff Rules and Regulations. The Podiatrist shall agree to

comply with all applicable Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, and policies and procedures.

- 6.10 Special Conditions for AHPs. Requests for Clinical Privileges by AHPs shall be processed in the manner specified in Article 4, as applicable. An AHP may, subject to any licensure requirements or other limitations, exercise independent judgment within the areas of the AHP's professional competence and participate directly in the medical management of patients under the supervision of a Practitioner who has been accorded Privileges to provide such care. Surgical procedures performed by an AHP, if any, are under the overall supervision of the Surgery Physician Coordinator. A Physician Member of the Medical Staff must perform a basic medical appraisal for each AHP patient, be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization, and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient.
- 6.11 Emergency Privileges. In case of an emergency as defined in this Section 6.11 of Article 6, any Medical Staff Member is authorized and shall be assisted to render medical treatment to attempt to save the patient's life or to save the patient from serious harm, as allowed within the Staff Member's scope of practice, and notwithstanding the Medical Staff Member's Service affiliation, Staff category or level of Clinical Privileges. A Practitioner exercising emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care. For purposes of this Section 6.11 of Article 6, "emergency" is defined as a situation where serious permanent harm is imminent or in which the life of a patient is in immediate danger and delay in administering treatment could increase the danger to the patient.
- 6.12 Temporary Privileges.
- (a) Temporary Privileges may be granted as described in Subsection 6.12(b) of this Article 6, and are available only to a Practitioner, when documentation submitted substantially supports that the requesting Practitioner has the requisite qualifications, ability and judgment to perform the Privileges requested, and only after the Practitioner shows that the professional liability insurance requirements of these Bylaws have been met. Temporary Privileges may be granted as described in Subsection 6.12(b) of this Article 6 only in the following events:
- (i) To fulfill an important patient care need; or
  - (ii) When an Applicant with a complete, clean Application is awaiting review and approval of the Medical Staff Executive Committee and the Board.

The Chief of Staff may impose a requirement that the relevant Physician Coordinator or the Physician Coordinator's designee shall consult and report regarding the Practitioner's activity in the Hospital during the temporary Privileges period. The Practitioner must agree in writing to comply with these Medical Staff Bylaws, the Medical Staff Rules and Regulations, Hospital Bylaws, Hospital Corporate Compliance Plan, and Hospital policies and procedures in matters relating to the Practitioner's activities in the Hospital.

- (b) After reviewing the favorable recommendation of the Chief of Staff, the Chief Executive Officer may grant temporary Privileges under the following circumstances:
- (i) Applicants: Temporary Privileges shall not be granted to Medical Staff Applicants except under circumstances as the Chief of Staff determines are

necessary for patient care or otherwise in the best interest of the Hospital. Upon recommendation of the Chief of Staff, the Chief Executive Officer or the Chief Executive Officer's designee may grant temporary Privileges to an Applicant for Medical Staff membership only after receipt of the following:

- a. Written verification of current licensure.
- b. Written verification of relevant training or experience.
- c. Written verification of current competence.
- d. Written verification of the ability to perform the Privileges requested.
- e. Written verification of the results of the National Practitioner Data Bank query.
- f. The Applicant has a complete Application, and the Applicant is waiting for review and recommendation by the Medical Staff Executive Committee and approval by the Board.
- g. The Applicant has no current challenge or previously successful challenge to licensure or registration.
- h. The Applicant has not been subject to involuntary termination of Medical Staff membership at another organization.
- i. The Applicant has not been subject to involuntary limitation, reduction or denial of Clinical Privileges.

Temporary Privileges to Applicants may be awarded for an initial period of up to thirty (30) days with subsequent renewals not to go beyond a total of one hundred twenty (120) days. Any such renewal of temporary Privileges can be made only upon the written recommendation of the Chief of Staff, applicable Physician Coordinator and the concurrence of the Chief Executive Officer, and is contingent upon the receipt of information that continues to support the granting of the Practitioner's Application for membership and Privileges. Temporary Privileges cannot be extended if the Application is still pending due to the Applicant's failure to respond in a satisfactory manner to a request for more information or clarification.

(ii) Patient Care Need:

- a. *Locum tenens*. Upon receipt of a written request, temporary Privileges may be granted to a Practitioner who is providing coverage for a member of the Medical Staff. *Locum tenens* Privileges may be granted initially for a maximum period of sixty (60) days and may be renewed for two (2) consecutive periods of thirty (30) days.
- b. Care of Specific Patients: Upon receipt of a written request, temporary Privileges may be granted to a Practitioner who possesses skills necessary to provide care to a patient that no other Practitioner currently holding Privileges at the Hospital possesses. Such Privileges may not be

granted in more than four (4) instances in any twelve (12)-month period, after which the Practitioner must apply for Staff membership.

- c. Verification Required: *Locum tenens* Privileges or Privileges for care of a specific patient may be granted only if the Hospital receives the following:
- A completed Application for appointment to the position sought, including a delineation of the specific Privileges requested;
  - A copy of or verbal confirmation from the appropriate authority of adequate licensure;
  - DEA/controlled substance registration;
  - Evidence of sufficient professional liability insurance;
  - Verification that the Practitioner is not on the U.S. Department of Health and Human Services Office of Inspector General Exclusion list or any other exclusion list affecting the Practitioner's ability to participate in state health care programs;
  - Written or verbal reference affirming current competence from a Medical Staff authority or appropriate administrative personnel at the Practitioner's current principal hospital affiliation; and
  - The recommendation of either the applicable Service Physician Coordinator or Chief of Staff.
- (c) Temporary Privileges shall not be routinely used for other administrative purposes, including, but not limited to, the licensed Practitioner's failure to provide all information necessary to process the Practitioner's appointment or reappointment in a timely manner and/or the failure of the Medical Staff to verify performance data and information in a timely fashion.
- (d) Upon receipt of information that raises doubts or concerns about a Practitioner's qualifications or specific temporary Privileges granted, and after discussion with Practitioner's supervising Physician Coordinator, the Chief Executive Officer or the Chief of Staff must determine whether to suspend or terminate a portion or all of a Practitioner's temporary Privileges. If the life or wellbeing of a patient is thought to be endangered, any person entitled to impose summary suspensions under these Bylaws may affect the termination. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Physician Coordinator responsible for supervision of the Practitioner. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.
- (e) The granting of temporary Privileges is a courtesy on the part of the Hospital. Neither the granting, denial, suspension nor the revocation of such Privileges shall entitle the Practitioner concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeal.

#### 7.13 Telemedicine.

- (a) The Clinical Privileges at Hospital related to the provision of telemedicine will include both the types of services that may be provided through telemedicine and the types of Practitioners and AHPs that are permitted to request Privileges to perform those services.
- (b) At the time of granting, renewal or revision to a Practitioner or AHP's Privileges to perform telemedicine services, whether to Hospital's patients or from Hospital to the patients of another entity, the Medical Staff will evaluate performance of those services as a part of the Privileging process and determine:
  - (i) The Clinical Services performed are appropriately delivered by Practitioners or AHPs through this medium;
  - (ii) The Clinical Services offered are consistent with commonly accepted quality standards; and
  - (iii) If the Practitioner is a Telemedicine Practitioner on the Medical Staff, whether the services are within the scope the Telemedicine Practitioner is to perform for the Hospital under the applicable contract.
- (c) If a Practitioner or AHP desires to provide services via telemedicine, the request for Clinical Privileges must specify telemedicine. Receipt of Clinical Privileges to provide a specific service in person does not automatically allow the Practitioner or AHP to provide the same service through telemedicine.

## **ARTICLE 7 - OFFICERS**

7.1 Officers of the Medical Staff. The officers of the Staff shall consist of a Chief of Staff, a Vice Chief of Staff and a Secretary.

7.2 Qualifications of Officers. Each officer shall:

- (a) Be a member in Good Standing of the Active Medical Staff at the time of nomination and election, and remain in Good Standing throughout the member's term of office. Any officer who fails to maintain such status shall immediately be removed from office.
- (b) Have been recognized for a high level of clinical competence in the member's field and have demonstrated executive and administrative ability through active participation in Staff activities and other experience.
- (c) Have demonstrated a high level of interest in and support of the Medical Staff and Hospital by the member's Staff tenure and the member's level of Clinical activity at Hospital.
- (d) Willingly and faithfully exercise the duties and authority of the office held and cooperate and work with the other officers, Physician Coordinators of the Staff, the Chief Executive Officer, the Board, and their respective committees.

7.3 Election of Officers.

- (a) Officers shall be elected, subject to Board approval, by a majority vote of those Active Staff Members in Good Standing who are present at the Medical Staff's annual meeting or by mail or electronic ballot. The decision to use mail or electronic ballot shall be at the

discretion of the Medical Executive Committee. If the elections are held by mail or electronic ballot, officers shall be elected by a majority vote of all Active Staff Members' ballots received within such time period as is established by the Medical Executive Committee. Officers so elected and approved by the Board shall take office on the January 1 following said meeting. If there are three (3) or more candidates for any office, and no candidate receives a majority of the votes cast, the name of the candidate who receives the fewest votes will be omitted from successive ballots until a majority vote is obtained by one (1) candidate.

- (b) At the discretion of the Medical Executive Committee, a nominating committee may be appointed. Such committee, if appointed, shall consist of three (3) members, and shall include the immediate past and current Chiefs of Staff and one (1) other Active Staff Member appointed by the Chief of Staff. This committee shall offer one (1) or more nominees for each office. The voting members of the Medical Staff shall be notified of the nominations in such manner as is determined by the Medical Executive Committee at least \_\_\_\_\_ Fourteen \_\_\_\_\_ (14) calendar days prior to election.
- (c) Nominations also may be made from the floor at the time of election.

7.4 Term of Office. Officers shall serve a one (1)-year term, but may be re-elected for two (2) additional terms up to a maximum of three (3) consecutive full-year terms. Each officer shall serve until the end of the officer's term and until a successor is elected, unless the officer sooner resigns or is removed from office.

7.5 Vacancies in Office. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. Vacancies in the other offices shall be filled by appointment by the Medical Executive Committee subject to Board approval.

7.6 Removal of Officers. Grounds for removal of any officer of the Medical Staff shall include, but are not limited to, (i) conduct that is detrimental to or reflects adversely on the Medical Staff or the Hospital, (ii) inability or failure to perform the necessary functions of the office held, or (iii) any action of conduct that would form the basis for corrective action pursuant to Article 12, even if corrective action is not taken. Removal of a Medical Staff officer may be initiated by the Board, the Medical Executive Committee or by a petition signed by at least one-third (1/3) of the members of the Active Medical Staff. Removal shall be considered at a special meeting called for that purpose. Removal shall require a two-thirds (2/3) vote of the Active Medical Staff or a majority vote by the Board. Voting may take place at any regular or special meeting of the Medical Staff or the Board or by mail or electronic ballots, as determined by the Medical Executive Committee or the Board. Written notice of any meeting at which removal of an officer or voting by mail or electronic ballots are to be considered, shall be delivered to all Medical Staff Members or Board Members entitled to vote at least seven (7) calendar days before the date of the voting.

7.7 Duties of Officers.

- (a) The Chief of Staff shall:
  - (i) Serve as the Chief Administrative Officer of the Medical Staff;
  - (ii) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;

- (iii) Aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff;
  - (iv) Call, preside at and oversee the preparation of the agenda for all general meetings of the Medical Staff;
  - (v) Serve as chairperson of the Medical Executive Committee;
  - (v) Serve as ex-officio member without vote of all other Medical Staff committees;
  - (vi) Be responsible for the following as they relate to the Medical Staff: enforcement of the Medical Staff Bylaws, Medical Staff Rules and Regulations, the Hospital Bylaws, policies and procedures, and Hospital Corporate Compliance Plan; implementation of sanctions where indicated; and compliance with appropriate procedure as set forth in these Bylaws in all instances where corrective action has been requested against a Practitioner;
  - (viii) Except with respect to the Medical Executive Committee, appoint committee members to all standing, special and disciplinary Medical Staff committees;
  - (ix) Meet with the Board and the Chief Executive Officer at least annually to report the views, needs, policies and grievances of the Medical Staff;
  - (x) 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 Medical Staff's delegated responsibility to provide medical care;
  - (xi) Be the spokesperson for the Medical Staff in its professional and public relations;
  - (xii) Be responsible for the educational activities of the Medical Staff;
  - (xiii) Direct the development, implementation, and day-to-day functioning and organization of the Medical Staff components of the quality review, risk management and utilization management programs; oversee that the programs are clinically and professionally sound in accomplishing program objectives and are in compliance with regulatory and accrediting agency requirements; and report to the Board regarding such programs and activities;
  - (xiv) Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws and other Hospital and Medical Staff Rules and Policies, and as may, from time to time, be reasonably requested by the Medical Executive Committee, the Board or Chief Executive Officer; and
  - (xv) Attend meetings of the Board.
- (b) The Vice Chief of Staff shall:

Perform all the duties and assume all the responsibilities of the Chief of Staff in the Chief of Staff's absence be a member of the Medical Executive Committee and succeed the Chief of Staff when the Chief of Staff fails to serve for any reason.

(c) The Secretary shall:

Call Medical Staff meetings at the request of the Chief of Staff, keep minutes of all Medical Staff meetings and Medical Executive Committee meetings, respond to all correspondence, and perform such other duties as ordinarily pertain to the office of Secretary. The Secretary shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the funds, if any, and business transactions of the Medical Staff and perform such other duties as ordinarily pertain to the office of Treasurer. The Secretary shall be a member of the Medical Executive Committee of the Medical Staff.

### **ARTICLE 8 - CLINICAL SERVICES**

- 8.1 Non-Departmental Staff. The Medical Staff shall constitute a unified Staff, without clinical Departments. The Medical Executive Committee will periodically reexamine the structure and recommend to the Board desirable or necessary actions in creating a new service or in establishing or reorganizing the Staff in order to promote improved efficiency and patient care.
- 8.2 The Every Staff Member must have a primary affiliation with the Service which most clearly reflects the Staff Member's professional training and experience in the Clinical area in which the Staff Member's practice is concentrated. A Practitioner may be granted Clinical Privileges in one (1) or more Services, and the Practitioner's exercise of Privileges within the jurisdiction of any Service is always subject to the Rules and Regulations of that Service and the authority of the Physician Coordinator.
- 8.3 Physician Coordinator; Election Qualifications, Appointment.
- (a) Each Service shall have at least one (1) Physician Coordinator who must be a member of the Active Medical Staff and of the applicable Service and remain in Good Standing throughout the Physician Coordinator's term and must be willing and able to faithfully discharge the functions of the Physician Coordinator's office. The Physician Coordinator shall demonstrate, through the Privilege delineation process, competence in the appropriate area of practice.
  - (b) The Chief of Staff, subject to Board approval, shall appoint the Physician Coordinators. Each Physician Coordinator will serve a one (1)-year term commencing upon appointment and continuing until the Physician Coordinator's successor is chosen, unless the Physician Coordinator sooner resigns or is removed from office. The Physician Coordinator may be eligible for reappointment.
- 8.4 Physician Coordinator; Responsibilities and Authority. Each Physician Coordinator shall:
- (a) Oversee professional and administrative activities within the Physician Coordinator's Service and report on such activities as requested by the Medical Executive Committee, the Chief Executive Officer or the Board;

- (b) Upon request, transmit to the Credentials Committee the Physician Coordinator's recommendations concerning appointment or reappointment, Staff category, and delineation of Clinical Privileges of all Practitioners in the Physician Coordinator's Service;
- (c) Assist in monitoring, on a continuing and concurrent basis, the performance of those with Clinical Privileges in the Service for adherence to Staff, Hospital and Service policies and procedures, including, but not limited to, requirements for alternate coverage and for obtaining consultation, for adherence to sound principles of Clinical practice generally, for unexpected patient care management events, and for patient safety;
- (d) Coordinate with Hospital Services and Hospital administration in matters affecting patient care in the Physician Coordinator's Service, including personnel, supplies, special regulations, standing orders and techniques; and
- (e) Perform such other duties as may be determined by the Medical Executive Committee.

8.5 Service Functions. Each Service shall perform the following functions:

- (a) Upon request, review and make recommendations regarding criteria for the granting of Clinical Privileges in the Service consistent with the policies of the Medical Staff and the Board;
- (b) Cooperate with the Performance Improvement/Quality Assurance Committee and the Utilization Review Committee in their retrospective review of completed records of discharged patients and others for the purposes of contributing to continuing education and to the process of developing criteria to help assure quality patient care and efficient and effective usage of health care services;
- (c) Meet, as necessary, to review and analyze the clinical work of the Service;
- (d) Receive and relay reports regarding performance improvement/quality assurance issues in the applicable Hospital Department for referral to the Performance Improvement/Quality Assurance Committee;
- (e) Provide input to the relevant Hospital Department's organizational plan to define the Service's role within the particular Hospital Department in which it operates; and
- (f) Be responsible for making available to the Service Members scientific or other educational programs as deemed necessary by the Medical Executive Committee.

8.6 Assignment. The Medical Executive Committee shall, after consideration of the recommendation of the Credentials Committee, recommend Service assignments for all Medical Staff Members and for all approved AHPs with Clinical Privileges in accordance with the guidelines of Section 8.2 of this Article 8.

8.7 Resignation and Removal. A Physician Coordinator may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time as specified in the notice. Removal may be effected by the Board acting upon its own initiative, by a two-thirds (2/3) majority vote of the Medical Executive Committee and subject to approval of the Board, or by a two-thirds (2/3) majority vote of the

applicable constituent group of the respective Service and subject to approval of the Board. An unexpected vacancy will be filled by the Medical Executive Committee through appointment of an acting officer subject to Board approval.

## ARTICLE 9 - COMMITTEES

### 9.2 Medical Executive Committee.

- (a) Composition: The Medical Executive Committee shall be a standing committee and shall consist of the **Officers**. At all times, Physician (Doctor of Medicine or osteopathy) Members of the Active Staff shall comprise at least a majority of the voting members of the Medical Executive Committee and may include other Practitioners and individuals as determined by the Organized Medical Staff. The Chief of Staff shall act as chairperson and a Representative of the Medical Records Department shall act as support Staff. In accordance with the Chief Executive Officer's duties as Chief Executive Officer, the Chief Executive Officer shall be entitled to attend each Medical Executive Committee, without vote.
- (b) Process for Selecting and/or Electing and Removing Medical Executive Committee Members: Members of the Medical Executive Committee shall be elected/appointed by [Do you want to appoint or elect the MEC? Vote of Board/medical staff?] \_\_\_\_\_. Once selected by the Medical Staff, the Medical Executive Committee Members shall be submitted to the Board for approval. Any committee member, including members of the Medical Executive Committee, may be removed by the individual or entity which elected or appointed the committee member. At large members of the Medical Executive Committee may be removed from the Executive Committee in the same manner as officers of the Medical Staff.
- (c) Duties: The duties of the Medical Executive Committee shall be:
  - (i) To represent and act on behalf of the Medical Staff, subject to any limitations as may be imposed by these Bylaws and those of the Hospital;
  - (ii) To coordinate the activities and general policies of the various Clinical Services;
  - (iii) To receive and act upon committee reports and recommendations;
  - (iv) To implement policies of the Medical Staff, including, but not limited to, enforcement of the Medical Staff Bylaws, the Medical Staff Rules and Regulations, the Hospital's Bylaws, and the Hospital Corporate Compliance Plan;
  - (v) To provide Coordinator among Medical Staff, the Chief Executive Officer and the Board;
  - (vi) To ensure that the Medical Staff is kept abreast of the Hospital's accreditation program and informed of the accreditation status of the Hospital;

- (vii) To review the credentials of all Applicants and to make recommendations to the Board for Staff membership assignments to Services and delineation of Clinical Privileges;
  - (viii) To review at least every two (2) years all information available regarding the performance and clinical competence of Staff Members and Allied Health Professionals with Clinical Privileges, and as a result of such reviews, to make recommendations for reappointments and renewal or changes in Clinical Privileges; (ix) To request evaluations of Practitioner Privileges through the Medical Staff process in instances where there is doubt about the Applicant's ability to perform Privileges requested;
  - (x) To make appropriate effort to ensure professional, ethical conduct and competent clinical performance by all Staff Members, including the initiation of and/or participation in Medical Staff corrective action or review procedures when warranted and implementation of any actions taken as a result thereof;
  - (xi) Investigate, review and report on any matters related to the conduct or clinical practice of any Practitioner in accordance with these Bylaws;
  - (xii) Oversee and direct medical education activities and programs for members of the Medical Staff;
  - (xiii) Participate in identifying community health needs and setting Hospital goals and establishing plans and programs to meet those needs;
  - (xiv) Recommend Clinical Services to be provided by telemedicine;
  - (xv) To report at general Staff meetings regarding the proceedings of all meetings and decisions made regarding Staff policy in the interim between Staff meetings;
  - (xvi) To make recommendations on Hospital management matters (e.g., long- range planning) to the Board through the Chief Executive Officer;
  - (xvii) To make recommendations to the Board regarding Medical Staff structure; participation of the Staff in performance improvement/quality assurance and utilization review activities; and mechanisms for Clinical Privileges delineation, credentials review, termination of Staff membership and fair hearing procedures;
  - (xviii) To act on behalf of the Medical Staff, if appropriate and subject to ratification by the Medical Staff, with respect to matters which require action prior to the next scheduled or special meeting of the Staff; and
  - (xix) To organize the Medical Staff's performance improvement/quality assurance, quality review and utilization management activities and establish a mechanism to conduct, evaluate and revise such activities.
- (d) Meetings: The Medical Executive Committee shall meet monthly and otherwise at the call of the Chief of Staff.

### 9.3 Credentials Committee.

- (a) Composition: The Credentials Committee shall be a standing committee, appointed by the Chief of Staff. A Representative of the Medical Records Department shall act as support Staff to the committee. The committee shall appoint a chairperson.
- (b) Duties: The duties of the Credentials Committee shall be:
  - (i) To review the credentials of all Applicants and to make recommendations to the Medical Executive Committee for membership and delineation of Clinical Privileges in compliance with Article 5 and 6 of these Bylaws;
  - (ii) To make a report to the Medical Executive Committee on each Applicant for Medical Staff membership and Clinical Privileges, including specific consideration of the recommendations from the Department [Service] in which the Applicant requests Privileges;
  - (iii) To review at least every two (2) years all information available regarding the qualifications and competence of Staff Members and, as a result of such review, to make recommendations for granting of Privileges, reappointments and assignment to the various Services as provided in these Bylaws. This will be reported in writing to the Medical Executive Committee at its December meeting;
  - (iv) To investigate any breach of ethics that is reported to it; and
  - (v) To review reports referred by the Staff Committees and by the Chief of Staff.
- (c) Meetings: The Credentials Committee shall meet at the call of the Chief of Staff or chairperson of the Committee.

#### 9.4 Joint Conference Committee.

- (a) Composition: The Joint Conference Committee is a standing committee composed of the Chief of Staff, the immediate past Chief of Staff, two (2) members of the Board of the Hospital appointed by the Chairperson of the Board , and the Chief Executive Officer. [A Representative of the Medical Records Department shall act as support Staff.] All members of the committee shall be entitled to vote except the Chief Executive Officer of the Hospital. The chairperson shall be the chairperson of the Board or the Board chairperson's appointee.
- (b) Duties: The duties of the Joint Conference Committee shall be to:
  - (i) Conduct itself as a forum for the discussion of administrative and medical policies and procedures requiring agreement among the, Medical Staff and Administration;
  - (ii) Oversee Hospital compliance with laws and regulations of federal, state and local government and with standards of the various accrediting and approval bodies;

- (iii) Consider the formulation and implementation of standards and activities for the review and maintenance of the quality and efficiency of patient care;
  - (iv) Review and recommend updates to Hospital's disaster preparedness activities; and
  - (v) Provide medico-administrative Coordinator between the Board of and Medical Staff, for discussion and interaction between the Board and Medical Staff on matters referred by the Medical Executive Committee or the Board.
- (c) Meetings: The Joint Conference Committee shall meet, as necessary, at the call of the chairperson of the Board or the Chief of Staff.

9.5 Performance Improvement/Quality Assurance Committee.

- (a) Composition: This committee shall consist of One ( 1 ) physicians appointed by the Chief of Staff for a one (1)-year term, the Director of Nursing, the Medical Records Director and the Chief Executive Officer. The Committee shall elect its own chairperson. Other Hospital Representatives may be invited to participate as indicated by various audit topics.
- (b) Duties:
  - (i) Medical Records and Review: The committee shall be responsible for assuring that the medical records reflect realistic documentation of medical events. The committee shall conduct a periodic review at least quarterly of selected records of current Hospital patients to assure that they reflect the diagnosis, results of diagnostic tests, therapy ordered, condition, in-hospital progress and condition of the patient at discharge, and that they are sufficiently complete at all times, so that in the event of transfer of patient responsibility, complete medical comprehension of the case is represented. The committee shall see that the medical reviews are conducted as required and that the results of these reviews are forwarded to the Medical Executive and Credentials Committees, which shall jointly prepare recommendations to the Medical Staff, Chief Executive Officer of the Hospital or other committees by way of the Chief of Staff. The committee shall maintain a permanent record of its proceedings and activities.
  - (ii) Ongoing Professional Practice Evaluation: The committee shall be responsible for assuring ongoing practice evaluation of Practitioners and AHPs, including, but not limited to, review of operative and other clinical procedures performed, patterns of blood and pharmaceutical usage, requests for tests and procedures, length of stay patterns, morbidity and mortality data, and Practitioner's use of consultants. Information obtained on each Practitioner or AHP through the ongoing professional practice evaluation will be incorporated into the Practitioner or AHP's Medical Staff file for inclusion in decisions regarding Clinical Privileges.
  - (iii) Performance Improvement/Quality Assurance Activities: The committee shall be responsible for assuring the implementation of a planned and systematic process for monitoring and evaluating the quality of the care and treatment of patients

served and the Clinical performance of all individuals with Clinical Privileges. The committee shall perform reviews of surgical procedures to help assure that surgery performed in the Hospital is justified and of high quality. The committee shall review and evaluate the quality of clinical practice of the Staff throughout the Hospital at least once each quarter. Review and evaluation shall include selected deaths, unimproved cases, tissue, infections, complications, error in diagnosis and results of treatment. The committee shall report in writing its conclusions, recommendations, action taken and the results of actions.

- (c) Meetings: The Performance Improvement/Quality Assurance Committee shall meet at least quarterly and otherwise at the call of the Chief of Staff, Chairperson of the Committee, Chief Executive Officer or Chairperson of the Board.

#### 9.6 Utilization Review Committee.

- (a) Composition: A Utilization Review Committee consisting of one (1) or more Practitioners must carry out the utilization review function. At least one (1) of the members of the committee must be Doctor of Medicine or osteopathy. As otherwise stated above, this committee shall consist of one (1) Physicians appointed by the Chief of Staff for a one (1)-year term, the Director of Nursing, the Medical Records Director, Social Worker and Business Office Manager. Other Hospital Representatives may be invited to participate as needed.
- (b) Duties:
  - (i) Utilization Review Studies: The committee shall conduct utilization review studies designed to assess and evaluate the appropriateness and/or efficiency of admissions to the Hospital, length of stay, discharge practices, use of medical and Hospital Services, and other factors that may contribute to the effective utilization of Hospital and Physician Services. Specifically, the committee shall analyze how under-utilization and over-utilization of each of the Hospital's Services affects the quality of patient care provided at the Hospital, study patterns of care and obtain criteria relating to average or normal (usual) lengths of stay by specific disease categories, and evaluate systems of utilization review employing such criteria. It also shall work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the Hospital. The committee shall communicate the results of its studies and other pertinent data to the entire Medical Staff and shall make recommendations for the optimum utilization of Hospital resources and facilities in accordance with quality of patient care and safety.
  - (ii) Other duties include: (1) the development of a written utilization review plan, which shall be approved by the Staff and the Board, which must be in effect at all times; (2) the completion of medical care evaluation studies, under criteria developed by the federal government's review organizations; and (3) the review of extended duration stays.
  - (c) Meetings: The Utilization Review Committee shall meet, as needed, at the call of the Chief of Staff, Chairperson of the Committee, Chief Executive Officer or Chairperson of the Board.

9.7 Pharmacy and Therapeutics Committee.

- (a) Composition: Membership shall consist of Representatives of the Medical Staff appointed by the Chief of Staff, the Hospital Pharmacist, a Representative of Nursing Services, the Infection Control Manager, the Performance Improvement/Quality Assurance Coordinator and the Director of the Laboratory. A Medical Records Representative and the Chief Executive Officer shall serve as advisory Staff to the committee and shall attend all meetings.
- (b) Duties: This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital. The committee shall assist in the formulation of professional policy statements regarding evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and other matters relating to obtaining, retaining and usage of drugs in the Hospital. It also shall perform the following specific functions:
  - (i) Serve in an advisory capacity to the Medical Staff and the Pharmacist with respect to the choice of available drugs;
  - (ii) Make recommendations regarding drugs to be stocked;
  - (iii) Develop and periodically review a formulary for use in the Hospital;
  - (iv) Prevent unnecessary duplication in stocking drugs and drugs-in-combination that have identical amounts of the same therapeutic ingredients;
  - (v) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital; and
  - (vi) Establish standards concerning the use and control of investigational drugs and/or research in the use of recognized drugs.
- (c) Meetings: This committee shall meet at least quarterly and send reports to the Medical Executive Committee regarding its activities.

9.8 Infection Control Committee.

- (a) Composition: Membership shall consist of Representatives of the Medical Staff appointed by the Chief of Staff, the Hospital Pharmacist, a Representative of Nursing Services, the Infection Control Manager, the Performance Improvement/Quality Assurance Coordinator and the Director of the Laboratory. A Medical Records Representative and the Chief Executive Officer shall serve as advisory Staff to the committee and shall attend all meetings.
- (b) Duties: The Infection Control Committee must develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. The committee shall be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program, and the supervision of infection control in all phases

of the Hospital's activities, including the operating rooms, recovery room and special care units. It shall study and supervise sterilization procedures, isolation procedures, disposal of infectious material, testing of Hospital personnel for carrier status and other situations as requested by the Medical Executive Committee. It shall be responsible for the overall cleanliness of the Hospital and shall communicate, through the Hospital management Representatives, with the Board on emergency problems.

- (c) Meetings: This committee shall meet quarterly, and shall maintain a record of its proceedings and activity and shall report in writing through its chairperson to the full Medical Staff.

9.9 Physician Health Committee. [omitted]

9.10 Special Committees.

- (a) Other committees, whether standing or ad hoc, may be established at the discretion of the Chief of Staff and/or the Medical Executive Committee.

**ARTICLE 10 –  
MEDICAL STAFF COMMITTEE AND SERVICE MEETINGS**

10.1 Medical Staff.

- (a) Regular meetings. There shall be twelve (12) Regular meetings of the Medical Staff to be held at the time and place as determined in accordance with the Medical Staff Rules and Regulations. The annual meeting of the Medical Staff will be the last regular meeting before the end of the calendar year. At the annual meeting, the retiring officers and committees shall make reports reviewing activities and achievements of the past year. The agenda also shall include the election of officers for the following year and recommendations for reappointment to the Staff. The regular meetings shall include, but not be limited to, a review and analysis of clinical work done in the Hospital as presented by the Performance Improvement/Quality Assurance Committee, the Utilization Review Committee or members of the Medical Staff.
- (b) Special Meetings:
  - (i) The Chief of Staff or the Medical Executive Committee may call a special meeting of the Staff at any time, including monthly meetings of the Medical Staff, if a decision is required by all available the Medical Staff. within [ ( 3 ) ] days of receipt of a request of such meeting signed by [ Fifty Percent ( 50% ) ] members of the Active Medical Staff and stating the purpose of such meeting.
  - (ii) Notice in writing or by phone stating the place, day and hour of any special meeting shall be delivered to each member of the Active Medical Staff not less than one (1) day before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.
- (c) Quorum. The presence of Fifty percent (50%) of the membership of the Active Medical Staff at any regular or special meeting, including a meeting, with a minimum of three members.(3) for the purpose of amendment of these Bylaws, shall constitute a quorum.

- (d) Attendance Requirements. All members of the Active Medical Staff shall be required to attend all meetings of the Staff, regular and special. Absence from Three (3) consecutive meetings of the Staff or from more than Five scheduled meetings in any calendar year without acceptable excuse shall result in reduction of Privileges to Courtesy or Provisional Active Staff for the next year with Active Staff Privileges pending the following year upon the fulfillment of the meeting requirement. The Medical Executive Committee shall decide if an excuse is acceptable or not. The Secretary or another person designated by the Chief of Staff shall notify any Medical Staff Member whose meeting attendance requirement has not been fulfilled of the reduction in Privileges and the Staff Member's procedural rights according to the Bylaws. Upon receipt of appropriate written notice from the affected Practitioner by the Chief of Staff, the Staff Member will be entitled to a hearing or other procedural rights in accordance with Article XIII. Reinstatement of members to Active Staff following this may be made on Application as in the case of original appointment.
- (e) Agenda:
- (i) The agenda at any regular Medical Staff meeting may be as follows:
- Call to order;
  - Acceptance of the minutes of the last regular and of all special meetings;
  - Unfinished business;
  - Communications;
  - Report of the Chief Executive Officer of the Hospital;
  - New business;
  - Presentation of interesting or pertinent findings stemming from utilization review and/or patient care evaluation studies;
  - Reports of standing and of special Medical Staff Committees;
  - Discussion and recommendations for improvement of professional work at the Hospital;
  - Educational programs; and - Adjournment.
- (ii) The agenda at special meetings shall include:
- The reading of the notice calling the meeting;
  - Transaction of business for which the meeting was called; and
  - Adjournment.
- (f) Written minutes of Medical Staff meetings shall be signed by the Secretary and permanently filed on a confidential basis in the Hospital.

## 10.2 Service and Committee Meetings.

- (a) Regular Meetings: Services shall hold meetings as called by the Physician Coordinator for that Service and shall meet to review and evaluate the clinical work of Practitioners with Service Privileges. All committees shall meet as specified in these Bylaws and may establish their own schedules in accordance with these Bylaws.
- (b) Special Meetings: A special committee meeting may be called by the Chief of Staff, the committee chairperson or by one-third (1/3) of the members of the committee.

- (c) Notice: Written or oral notice stating the place, day and hour of any committee meeting shall be given to each member not less than twenty-four (24) hours before the time of the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.
- (d) Quorum: Fifty percent (50 % ) of the Active Staff Members of a committee but not less than Three (3) members, shall constitute a Quorum at any meeting.
- (e) Manner of Action: The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the committee or Service. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote thereon.
- (f) Minutes: Minutes of each regular and special meeting of a committee or Service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall then be approved, signed by the Secretary and forwarded to the Medical Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting.
- (g) Attendance Requirements: All members of the Active Staff shall be encouraged to attend all meetings of committees and Services of which they may be members.

#### **ARTICLE 11 - INVESTIGATION AND CORRECTIVE ACTION**

11.1 Grounds for Corrective Action. Corrective action against a Practitioner with Staff membership or Clinical Privileges may be initiated whenever the Practitioner engages in or exhibits actions, statements, demeanor or conduct, either within or outside the Hospital, that is, or is reasonably likely to be:

- (a) Contrary to these Bylaws, the Medical Staff Rules and Regulations, the Hospital's Bylaws, policies or procedures, or the Hospital's Corporate Compliance Plan;
- (b) Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital;
- (c) Disruptive to Hospital operations;
- (d) Damaging to the Medical Staff's or the Hospital's reputation; (e)

Below the applicable standard of care; or

- (f) In violation of any law or regulation relating to federal or state reimbursement programs.

11.2 Authorization to Initiate. Any of the following may request that corrective action be taken

- (a) Any officer of the Medical Staff;

- (b) A Physician Coordinator of any Service in which the Practitioner holds membership or exercises Privileges;
- (c) Any standing committee or subcommittee of the Medical Staff (including the Medical Executive Committee) or a chairperson thereof; (d)

The Chief Executive Officer; or

- (e) The Board.

- 11.3 Discretionary Interview; Resolution Prior to Investigation or Request for Corrective Action. When a party authorized to initiate a corrective action under Section 11.2 receives information that may provide grounds for corrective action under Section 11.1, the party considering initiating an investigation or request for corrective action may, but is not obligated to, afford the Practitioner an interview at which the circumstances prompting the potential investigation are discussed and the Practitioner is permitted to present relevant information on the Practitioner's own behalf. The interview provided in this Section 11.3 of Article 11 is not a procedural right of the Practitioner and need not be conducted according to the procedural rules provided in Article 12 of these Bylaws. The party initiating the interview shall prepare a dated, written record of the interview indicating the type of problem, what was discussed with the Practitioner and any proposal as to the type of intervention that will be undertaken to address the problem. This written report shall be forwarded to the Medical Executive Committee and shall be retained in the Practitioner's confidential peer review file. If the interview does not fully resolve the potential situation giving rise for corrective action, the individual may initiate formal investigation by requesting a corrective action under Section 11.4.
- 11.4 Initiation, Requests, Notices. All requests for corrective action shall be submitted to the Medical Executive Committee in writing, and shall be supported by a statement of the specific activities or conduct that constitutes the grounds for the request. The Chief of Staff shall promptly notify the Chief Executive Officer in writing of all such requests.
- 11.5 Informal Interview. Upon receipt of a request for corrective action, the Medical Executive Committee or its designee may, at the Committee's option, conduct an informal interview with the Practitioner against whom corrective action has been requested. At such interview, the Practitioner will be informed of the general nature of the charges against the Practitioner and will be invited to discuss, explain or refute them. This interview shall not constitute an "investigation" or a "hearing," will be preliminary in nature, and will not be subject to any of the procedural rules provided in these Bylaws with respect to hearings. A summary of such interview shall be included with the report from the Medical Executive Committee to the Board of the Hospital and shall be placed in the Practitioner's confidential peer review file.
- 11.6 Investigation. Upon receipt of the request for corrective action, and following any informal interview with the affected Practitioner as described in the preceding Section 11.5 or Section 11.3 above, the Medical Executive Committee shall either act on the request or direct, by written resolution, that a formal investigation concerning the grounds for the corrective action request be undertaken. The Medical Executive Committee may conduct such investigation itself or may assign the task to a Medical Staff officer, a Service Physician Coordinator, a standing or ad hoc committee, an individual or group who is not affiliated with the Hospital, or any other Medical Staff component. This investigative process is not a "hearing" as that term is used in Article 12 and shall not entitle the Practitioner to the procedural rights provided in said Article 12. The investigative process may include, without limitation, a consultation with the Practitioner involved, with the individual or group who made the

request and with other individuals who may have knowledge of or information relevant to the events involved. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual shall submit a written report of the investigation to the Medical Executive Committee as soon as is practicable after the group's or individual's receipt of the assignment to investigate. The Medical Executive Committee may, at any time in its discretion, and shall at the request of the Board, terminate the investigative process and proceed with action as provided below. If the investigating group or individual has reason to believe that Practitioner's conduct giving rise to the request for corrective action was the result of a physical or mental disability, the Medical Executive Committee may require the Practitioner involved to submit to an impartial physical or mental evaluation within a specified time and pursuant to guidelines set forth below. Failure by the Practitioner to comply, without good cause, shall result in immediate suspension of the Practitioner's Medical Staff membership and all Clinical Privileges until such time as the evaluation is completed, the results are reported to the Executive Committee and the Board takes final action. The Executive Committee shall name the Practitioner(s) who will conduct the examination. The Hospital shall pay for the examination. All reports and other information resulting from the mental or physical evaluation shall be maintained in a separate file as a confidential medical record.

11.7 Medical Executive Committee Action. As soon as practicable after the conclusion of the investigative process, if any, the Medical Executive Committee shall act upon the request for corrective action. Its action may include recommending, without limitation, the following:

- (a) Rejection of the request for corrective action;
- (b) Verbal warning or a letter of reprimand;
- (c) Education and/or training;
- (d) Medical or psychiatric treatment or referral of the Practitioner to the Oklahoma Physicians Health Program or similar impaired provider program;
- (e) A probationary period with retrospective review of cases and/or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision;
- (f) A requirement of prior or concurrent consultation or direct supervision;
- (g) A limitation of the right to admit patients;
- (h) Reduction, suspension or revocation of all or any part of the Practitioner's Clinical Privileges; or
- (i) Suspension or revocation of the Practitioner's Medical Staff membership.

11.8 Effect of Medical Executive Committee Action.

- (a) When the Medical Executive Committee's recommendation is adverse (as defined in Article 12 of these Bylaws) to the Practitioner, the Chief Executive Officer of the Hospital shall immediately inform the Practitioner by Special Notice, and the Practitioner shall be entitled, upon timely and proper request, to the procedural rights contained in Article 12.

- (b) When the Medical Executive Committee's recommendation is favorable to the Practitioner, the Chief Executive Officer of the Hospital shall promptly forward it, together with all supporting documentation, to the Board. Thereafter, the procedure set forth in Article 5, Subsection 5.7(f)(i), is applicable.
- (c) If the Medical Executive Committee fails to act in processing and recommending action on a request for corrective action within an appropriate time as determined by the Board, the procedure set forth in Article 5, Subsection 5.7(f)(ii), shall be applicable.

11.9 Other Action. The commencement of corrective action procedures against a Practitioner shall not preclude the summary suspension of all or any portion of any of said Practitioner's Clinical Privileges in accordance with the procedure set forth in Section 1.10 of this Article 11.

11.10 Summary Suspension.

- (a) Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect the life of any patient(s) or to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee or other person present in the Hospital or to preserve the continued effective operation of the Hospital, any of the following has the authority to suspend summarily the Medical Staff membership or all or any portion of the Clinical Privileges of such Practitioner:
  - (i) The Chief of Staff;
  - (ii) The applicable Physician Coordinator;
  - (iii) The Chief Executive Officer, after conferring when possible with either the Chief of Staff, the immediate Past Chief of Staff, the appropriate Physician Coordinator or the Credentials Committee chairperson;
  - (iv) The Medical Executive Committee; or
  - (v) The Board.
- (b) A summary suspension is effective immediately. The person or group imposing the suspension shall immediately inform the Chief Executive Officer of the suspension, and the Chief Executive Officer shall promptly give Special Notice thereof to the Practitioner. The applicable Physician Coordinator shall assign a suspended Practitioner's patients then in the Hospital to another Practitioner, considering the wishes of the patient, where feasible, in selecting a substitute Practitioner.
- (c) As soon as possible, [but in no event later than fourteen (14) days] after a summary suspension is imposed, the Medical Executive Committee shall convene to review and consider the need, if any, for a professional review action. Such a meeting of the Medical Executive Committee shall in no way be considered a "hearing" as contemplated in Article 12 (even if the Practitioner involved attends the meeting), and no procedural requirements shall apply. The Medical Executive Committee may recommend modification, continuation or termination of the terms of the summary suspension.

- (d) The effect of the Medical Executive Committee’s action shall be as set forth in Section 11.8 of this Article 11. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision of the Board.

11.11 Automatic Suspension or Revocation. A Practitioner's Medical Staff membership and/or Clinical Privileges may be immediately suspended or revoked in any of the following situations:

(a) Occurrences Affecting Licensure:

- (i) Revocation: When a Practitioner’s license to practice in Oklahoma is revoked, the Practitioner's Medical Staff membership and Clinical Privileges shall be immediately and automatically revoked as of the date of license revocation.
- (ii) Restriction: When a Practitioner’s license to practice in Oklahoma is limited or restricted, those Clinical Privileges that the Practitioner has been granted that are within the scope of the limitation or restriction are similarly automatically limited or restricted as of the date of license limitation or restriction.
- (iii) Suspension: When a Practitioner’s license to practice in Oklahoma is suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically suspended effective upon and for the term of the suspension.
- (iv) Probation: When a Practitioner is placed on probation by the Practitioner's licensing authority, the Practitioner's voting and office-holding Privileges are automatically suspended effective upon and for at least the term of the licensure probation.

(b) Occurrences Affecting Controlled Substances Regulation:

- (i) Revocation: Whenever a Practitioner’s Drug Enforcement Administration (DEA) or other controlled substances number is revoked, the Practitioner shall be immediately and automatically divested of the Practitioner's right to prescribe medications covered by the number.
- (ii) Suspension or Restrictions: When a Practitioner’s DEA or other controlled substances number is suspended or restricted in any manner, the Practitioner's right to prescribe medications covered by the number is similarly suspended or restricted during the term of the suspension or restriction.

(c) Medical Records Completion: After written warning (and failure to cure by proscribed date) by the Medical Executive Committee of delinquency or failure timely to prepare or complete medical records, a Practitioner’s Clinical Privileges (except with respect to the Practitioner's patients already in the Hospital, already reserved for admission or surgery, and emergency situations), admitting rights, right to consult with respect to new patients, and voting and office-holding Prerogatives shall be automatically suspended. The suspension shall be effective on the date specified in the warning and shall continue until the delinquent records are prepared or completed.

(d) Professional Liability Insurance: Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer shall result in

immediate and automatic suspension of Practitioner's Medical Staff membership and Clinical Privileges until such time as a certificate of appropriate insurance coverage is furnished.

- (e) Exclusion from State or Federal Health Care Reimbursement Programs: Upon exclusion, debarment or other prohibition from participation in any state or federal health care reimbursement program, the Practitioner's Medical Staff membership and Clinical Privileges shall be immediately and automatically suspended until such time as the exclusion, debarment or prohibition is lifted.
- (f) Conviction of a Crime: Upon conviction of a felony or a crime involving moral turpitude in any court of the United States, either federal or state, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically revoked.
- (g) Procedure:
  - (i) An automatic suspension is effective immediately. The person or group imposing the suspension shall immediately inform the Chief Executive Officer of the suspension, and the Chief Executive Officer shall promptly give Special Notice thereof to the Practitioner. The applicable Physician Coordinator shall assign a suspended Practitioner's patients then in the Hospital to another Practitioner, considering the wishes of the patient where feasible, in selecting a substitute Practitioner.
  - (ii) The Practitioner will be given thirty (30) calendar days to produce clear and convincing evidence that the facts relied upon by the Hospital in imposing the automatic suspension are incorrect. In the absence of clear and convincing evidence to the contrary, the individual's Medical Staff membership and Clinical Privileges shall automatically terminate.
  - (iii) In the event the Practitioner produces clear and convincing evidence disputing the facts relied upon, the Chief Executive Officer may either reinstate the Practitioner or provide notice of a hearing under Article 12.
- (h) Procedural Rights and Additional Corrective Action: No Practitioner shall be entitled to the procedural rights set forth in Article 12 as a result of the sanctions automatically imposed pursuant to the preceding Subsections 11.11(a) through (f) of this Article 11. Any of the persons entitled to initiate corrective actions under Section 11.2 of this Article 11 may, however, initiate such action on the basis of any of the occurrences specified in Subsections 11.11(a) through (f) of this Article 11, and if, as a result thereof, an adverse recommendation or decision is made which exceeds the scope of the sanctions automatically imposed under Subsections 11.11(a) through (f) of this Article 11, then the Practitioner shall be entitled to the same procedural rights to which the Practitioner would be entitled under Section 11.8 of this Article 11, but only with respect to the additional sanctions recommended or imposed.

11.12 Reporting. The Chief Executive Officer shall report any corrective action taken pursuant to these Bylaws to the appropriate authorities as required by law and in accordance with applicable Hospital procedures regarding the same.

## **ARTICLE 12 - HEARING AND APPELLATE REVIEW PROCEDURE**

- 12.1 Purpose. The purpose of this Article 12 shall be to provide a mechanism for intraprofessional resolution of matters bearing on the professional competency and conduct of Practitioners who have Medical Staff membership and Clinical Privileges at Hospital.
- 12.2 Right to Hearing. Except as otherwise specifically provided in these Bylaws, the recommendations set forth in Subsection 12.2(a) of this Article 12 shall, if deemed adverse pursuant to Subsection 12.2(b) of this Article 12, entitle the Practitioner thereby affected to a hearing.
- (a) Recommendations or Actions:
- (i) Denial of initial appointment or subsequent reappointment to the Medical Staff;
  - (ii) Suspension or revocation of Medical Staff membership;
  - (iii) Denial of requested appointment to or advancement in Medical Staff category;
  - (iv) Involuntary reduction in Medical Staff category;
  - (v) Limitation of admitting Privileges not related to standard administrative or Medical Staff Policies;
  - (vi) Denial of requested affiliation with a Service;
  - (vii) Denial or restriction of requested Clinical Privileges other than a denial or restriction of temporary Privileges; or
  - (viii) Reduction, suspension or revocation of Clinical Privileges other than reduction, suspension or revocation of temporary Privileges.
- (b) When Deemed Adverse: A recommendation or action listed in Subsection 12.2(a) of this Article 12 shall be deemed adverse only when it has been:
- (i) Recommended by the Medical Executive Committee;
  - (ii) Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee; or
  - (iii) Taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Staff.
- (c) Actions Which Do Not Give Right to Hearing: Notwithstanding the provisions of Subsections 12.2(a) and (b) of Article 12, no action described in this Subsection 12.2(c) of Article 12 shall constitute grounds for or entitle the Practitioner to request a hearing.
- (i) An oral or written reprimand or warning;
  - (ii) Imposition of any general consultation requirement or any requirement that the Practitioner must be supervised while performing certain procedures;

- (iii) Imposition of a probationary period with retrospective or prospective review of cases;
- (iv) Denial of requested Privileges because the Practitioner failed to satisfy the basic qualifications or criteria of training, education or experience established for the granting of Privileges for a specific procedure or procedures;
- (v) Ineligibility for Medical Staff appointment or reappointment or the Clinical Privileges requested because a Service has been closed or there exists an exclusive contract limiting the performance of Privileges within the specialty with which the Practitioner is associated or the Clinical Privileges which the Practitioner has requested to one (1) or more Physicians;
- (vi) Termination or revocation of Medical Staff appointment or Clinical Privileges either in whole or in part because the Hospital has determined to close a Department [Service] or grant an exclusive contract limiting the performance of Privileges within the specialty in which the Practitioner practices to one (1) or more Physicians;
- (vii) Termination of the Practitioner's employment or other contract for Services unless the employment contract or Services contract provides otherwise;
- (viii) Ineligibility for Medical Staff appointment or requested Clinical Privileges because of lack of facilities or equipment or because Hospital has elected not to perform, or does not provide, the Service which the Practitioner intends to provide or the procedure for which Clinical Privileges are sought;
- (ix) Revocation, suspension or restriction of Clinical Privileges or Medical Staff appointment or denial of Medical Staff reappointment because of the failure of the Practitioner to comply with requirements of the Medical Staff Bylaws or Medical Staff Rules and Regulations pertaining to any required attendance at committee, Department [Service] or general Medical Staff meetings, or payment of required dues or any other requirement not based on professional competence or conduct;
- (x) Reduction, suspension or revocation of Medical Staff appointment or Clinical Privileges as provided in Section 11.11 of Article 11 regarding automatic suspension or revocation;
- (xi) Voluntary suspension or relinquishment of Clinical Privileges or Medical Staff membership when professional competence or conduct is not under investigation;
- (xii) Voluntary suspension or relinquishment of Clinical Privileges or Medical Staff membership, which is not in return for the Medical Staff refraining from conducting an investigation of professional competence or conduct;
- (xiii) The imposition of a requirement for retraining, additional training or continuing education; or
- (xiv) Suspension of Privileges, either in whole or in part, or Medical Staff membership for less than thirty (30) days and during which an investigation is being conducted to determine the need for further action.

- 12.3 Notice of Adverse Recommendation or Action. A Practitioner against whom an adverse action has been taken or recommended pursuant to Section 12.1 of this Article 12 shall be given Special Notice of such action. The notice shall:
- (a) Advise the Practitioner of the nature of and reasons for the proposed action;
  - (b) Advise the Practitioner that the Practitioner has thirty (30) days after receiving the Notice within which to submit a request for hearing on the proposed action;
  - (c) Include a summary of the Practitioner's rights in the hearing, which at a minimum includes the rights described in Subsection 12.8(d) of this Article 12;
  - (d) State that if the Practitioner fails to request a hearing in the manner and within the time period prescribed, such failure shall constitute a waiver of the right to a hearing and to an appellate review on the issue that is the subject of the Notice; and
  - (e) State that if the Practitioner properly requests a hearing, the Practitioner shall be provided with written notice of the date, time and place of the hearing. Such notice also shall state the grounds upon which the adverse recommendation or action is based.
- 12.4 Request for Hearing. A Practitioner shall have thirty (30) days after the Practitioner's receipt of a Notice pursuant to Section 12.3 of this Article 12 to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either in person or by certified mail.
- 12.5 Waiver by Failure to Request Hearing. A Practitioner, who fails to request a hearing within the time and in the manner specified in Section 12.4 of this Article 12, waives any right to such hearing and to any appellate review to which the Practitioner might otherwise have been entitled. Such waiver shall constitute acceptance of the adverse action or recommendation, and the adverse action or recommendation shall become a final action.
- 12.6 Right to One (1) Hearing and Appellate Review. Notwithstanding any other provision of this Article 12 to the contrary, no Practitioner shall be entitled as a matter of right to more than one (1) hearing and one (1) appellate review on any matter for which there is a hearing right. Adverse recommendations or actions on more than one (1) matter may be consolidated and considered together or separately, as the Board shall designate in its sole discretion.
- 12.7 Hearing Requirements.
- (a) Notice of Time and Place for Hearing: Upon receipt from a Practitioner of a timely and proper request for hearing, the Chief Executive Officer shall deliver the same to: (i) the Chief of Staff if the request for hearing was prompted by an adverse recommendation of the Medical Executive Committee under Section 12.2(b)(i), or (ii) to the Chairperson of the Board if the request for hearing was prompted by an adverse recommendation or action of the Board under Section 12.2(b)(ii) or (iii). Within ten (10) days after receipt of such request, the Chief of Staff or the Chairperson of the Board, as applicable, shall schedule and arrange for a hearing. At least thirty (30) days prior to the hearing, the Chief Executive Officer on behalf of the Executive Committee or the Board, as applicable, shall send the Practitioner Special Notice of the time, place and date of the hearing, which the date shall not be less than thirty (30) nor more than sixty (60) days after the date of the Notice. Provided, however, that

subject to the foregoing, a hearing for a Practitioner who is under summary suspension shall be held as soon as the arrangements may be reasonably made. The Special Notice of the hearing provided to the Practitioner shall include a list of witnesses (if any) expected to testify at the hearing in support of the proposed action and a summary of the Practitioner's rights according to these Bylaws.

- (b) Statement of Issues and Events: The Special Notice of hearing shall contain a concise statement of the Practitioner's alleged acts or omissions, a list of the specific or representative patient records in question, and/or a concise statement of any other reasons or subject matter forming the basis for the adverse action, which is the subject of the hearing.
- (c) Conduct of Hearing: If the adverse action that is the subject of the hearing was recommended by the Medical Staff Executive Committee, the hearing shall be held before a hearing officer or Hearing Committee as determined by the Chief of Staff. If the Board took the adverse action, the chairperson of the Board shall determine whether the hearing shall be held before a hearing officer or a Hearing Committee. The hearing officer shall be appointed by either the Chief of Staff or the chairperson of the Board pursuant to Subsection 12.7(d) of this Article 12. A Hearing Committee shall be appointed by either the Chief of Staff or the chairperson of the Board pursuant to Subsection 12.7(e) of this Article 12.
- (d) Appointment of Hearing Officer: The hearing officer may be a Physician, Dentist, attorney or other individual qualified to conduct the hearing. The hearing officer is not required to be a member of the Medical Staff. The hearing officer shall not be in direct economic competition with the Practitioner involved in the hearing.
- (e) Appointment of Hearing Committee:
  - (i) By Chief of Staff: A Hearing Committee appointed by the Chief of Staff shall consist of at least three (3) members of any Staff category of the Hospital, one (1) of whom shall be designated as chairperson by the Chief of Staff. Notwithstanding the foregoing, if, because of the requirements of Subsection 12.7(e)(iii) of this Article 12, or for any other reason, it is not possible to include members of the Medical Staff of Hospital on the Hearing Committee, the Hearing Committee may include members of the active Medical Staff of any hospital. The Chief of Staff shall designate one (1) of the appointees as chairperson of the Hearing Committee.
  - (ii) By Chairperson of the Board: A Hearing Committee appointed by the Chairperson of the Board shall consist of at least three (3) persons. One of the members shall be designated as chairperson by the chairperson of the Board. Subject to the provisions of Subsection 12.7(e)(iii) of this Article 12, at least one (1) member of the committee shall be a member of the Medical Staff when possible. Other members of the committee are not required to be members of the Medical Staff, and if no member of the Medical Staff is available because of the provisions of Subsection 12.7(e)(iii) of this Article 12, the Hearing Committee may include a member of the active Medical Staff of any hospital.
  - (iii) Service on Hearing Committee: A Practitioner or Board Member shall not be disqualified from serving on a Hearing Committee merely because the Practitioner or Board Member participated in initiating or investigating the underlying matter at issue or because the Practitioner or Board Member has heard of the case. However, no member of the Hearing Committee may be in direct economic competition with

the Practitioner involved in the hearing. All members of the Hearing Committee shall be required objectively to consider and decide the case with good faith.

- (iv) Presiding Officer: An individual qualified to conduct hearings may be designated as the presiding officer for a hearing to be heard by the Hearing Committee. Such individual need not be a member of the Hearing Committee.
- (f) List of Witnesses: In addition to the list of witnesses required in the Special Notice of hearing, at least five (5) days prior to the scheduled date for commencement of the hearing, each party shall provide the other with a list of names of the individuals who, as far as then reasonably known, will give testimony or evidence in support of that party at the hearing. Admissibility of testimony to be presented by a witness not so listed shall be at the discretion of the presiding officer.

## 12.8 Hearing Procedure.

- (a) Forfeiture of Hearing: A Practitioner who requests a hearing pursuant to this Article 12 but fails to appear at the hearing without good cause, as determined by the Hearing Committee or hearing officer, shall forfeit the Practitioner's rights to such hearing and to any appellate review to which the Practitioner might otherwise have been entitled.
- (b) Presiding Officer: The hearing officer, the chairperson or the individual designated pursuant to Subsection 12.7(e)(iv) of Article 12, shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing process are provided a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of evidence.
- (c) Representation: The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in Good Standing, by a member of the Practitioner's professional society and/or by an attorney. The Medical Staff or the Board may appoint a member of the Medical Staff in Good Standing and/or an attorney to represent the Medical Staff or the Board at the hearing to present the facts in support of its adverse recommendation or action, and to examine witnesses.
- (d) Rights of Parties: During the hearing, each party may:
  - (i) Call, examine and cross-examine witnesses;
  - (ii) Introduce any relevant evidence, including exhibits;
  - (iii) Question any witness on any matter relevant to the issues that are the subject of the hearing;
  - (iv) Impeach any witness;
  - (v) Offer rebuttal of any evidence;
  - (vi) Have a record made of the hearing in accordance with Subsection 12.8(h) of this Article 12; and

- (vii) Submit a written statement at the close of the hearing.
- (e) Procedure and Evidence: At the hearing, the rules of law relating to examination of witnesses or presentation of evidence need not be strictly enforced, except that oral evidence shall be taken only on oath or affirmation. If the Practitioner who requested the hearing does not testify in the Practitioner's own behalf, the Practitioner may be called and examined as if under cross examination. The hearing officer or hearing panel may consider any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs regardless of whether such evidence would be admissible in a court of law. Prior to or during the hearing, any party may submit memoranda concerning any procedural or factual issue, and such memoranda shall be included in the hearing record.
- (f) Information Pertinent to Hearing: In reaching a decision, the Hearing Committee or hearing officer shall be entitled to consider any pertinent material contained on file in the Hospital, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with Applications for appointment or reappointment to the Medical Staff and for Clinical Privileges. The Hearing Committee or hearing officer may at any time take official notice of any generally accepted technical or scientific principles relating to the matter at hand and of any facts that may be judicially noticed by the Oklahoma courts. The parties to the hearing shall be informed of the principles or facts to be noticed, and the same shall be noted in the hearing record. Any party shall be given the opportunity, upon timely request, to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the hearing officer or committee.
- (g) Burden of Proof: When a hearing relates to denial, limitation or other restriction of a Practitioner's request for new status or Privileges, including an initial Application for appointment, the Applicant shall have the burden of producing evidence to demonstrate that the adverse decision or recommendation lacks any substantial factual basis or that the basis or the conclusions drawn therefrom are arbitrary, unreasonable or capricious. Otherwise, the body whose adverse decision or recommendation is under consideration at the hearing shall have the initial obligation to present evidence in support thereof, but the Practitioner thereafter is responsible for supporting the Practitioner's challenge that the adverse decision or recommendation lacks any substantial factual basis or that the basis or the conclusions drawn therefrom are arbitrary, unreasonable or capricious.
- (h) Record of Hearing: A record of the hearing shall be kept of sufficient accuracy that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee or hearing officer may select the method to be used for making the record, such as a court reporter, electronic recording unit, detailed transcription or minutes of the proceedings. Upon request, the Practitioner shall be entitled to obtain a copy of the record or use an alternative recording method, at the Practitioner's own expense.
- (i) Postponement: Requests for postponement of a hearing may be granted by the chairperson of the Hearing Committee or the hearing officer upon a showing of good cause and only if the request is made as soon as is reasonably practical.
- (j) Presence of Hearing Committee Members and Vote: A majority of the Hearing Committee shall be present at all times during the hearing and deliberations. If a committee member is absent from any part of the proceedings, the presiding officer in the presiding officer's discretion may

rule that such member be excluded from further participation in the proceedings or recommendations of the committee.

- (k) Recesses and Adjournment: The Hearing Committee or hearing officer may recess the hearing and reconvene it without additional notice if the committee or officer deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. When presentation of oral and written evidence is complete, the hearing shall be closed. The Hearing Committee shall deliberate outside the presence of the parties and at such time and in such location as is convenient to the committee. Upon conclusion of the Hearing Committee's deliberations, the hearing shall be adjourned.

#### 12.9 Report and Further Action.

- (a) Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee or hearing officer shall report in writing all findings and recommendations with specific references to the hearing record and other documentation considered and shall forward the report along with the record and other documentation to the body whose adverse recommendation or decision occasioned the hearing.
- (b) Within twenty (20) days after receipt of the report, the Medical Executive Committee or the Board, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. The decision shall be transmitted, together with the hearing record, the report of the Hearing Committee or hearing officer and all other documentation considered to the Chief Executive Officer.
- (c) If the Medical Executive Committee's decision pursuant to 12.9(b) is adverse to the Practitioner, it shall have the notice and effect provided in Section 12.9(d) of this Article 12. If the Medical Executive Committee's decision pursuant to Subsection 12.9(b) of this Article 12 is favorable to the Practitioner, the Committee shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the Medical Executive Committee's decision in whole or in part or by referring the matter back to the Medical Staff Executive Committee for further consideration. Any such referral shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take action. The Chief Executive Officer shall, on behalf of the Board or Medical Executive Committee, as applicable, promptly send notice to the affected Practitioner informing the Practitioner of each action taken pursuant to this Subsection 12.9(c) of Article 12. A favorable determination shall become the final action of the Board, and the matter shall be considered closed.
- (d) Notice and Effect of Result.
  - (i) Notice: The Chief Executive Officer, on behalf of the body that made the decision, shall promptly send Special Notice, including a copy of the decision, to the affected Practitioner, to the Chief of Staff and to the Board.
  - (ii) Effect of Favorable Result: If the Board's decision pursuant to Subsection

12.9(b) or (c) of this Article 12, as applicable, is favorable to the Practitioner, such result shall become the final decision of the Board, and the matter shall be considered closed.

- (iii) Effect of Adverse Result: If the decision of the Medical Executive Committee or of the Board continues to be adverse to the affected Practitioner, the Special Notice required by Subsection 12.9(d)(i) of this Article 12 shall inform the affected Practitioner of the Practitioner's right to request an appellate review by the Board as provided in Section 12.10 of this Article 12.

#### 12.10 Initiation and Prerequisites of Appellate Review.

- (a) Request for Appellate Review: A Practitioner shall have fifteen (15) days after receiving Special Notice of the Practitioner's right to request an appellant review to submit a written request for such review. Such request shall be directed to the Board in care of the Chief Executive Officer in person or by certified mail and may include a request for a copy of the Hearing Committee report and record of all other material, favorable or unfavorable, if not previously forwarded, that was considered in taking the adverse action. If the Practitioner wishes an attorney to represent the Practitioner at any appellate review appearance permitted in this Article 12, the Practitioner's request for appellate review shall so state.
- (b) Waiver by Failure to Request Appellate Review: A Practitioner who fails to request an appellate review in accordance with Subsection 12.10(a) of this Article 12 waives any right to such review. Such waiver shall have the same force and effect as provided in Section 12.5 of this Article 12 regarding waiver by failure to request a hearing.
- (c) Notice of Time and Place for Appellate Review: Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review, which shall not be less than fifteen (15) days nor more than thirty (30) days after receipt by the Chief Executive Officer of the request for review; provided, however, that an appellate review for a Practitioner who is under summary suspension shall be held as soon as the arrangements for the appellate review may be reasonably made, but not later than fifteen (15) days after the Chief Executive Officer's receipt of the request. At least ten (10) days prior to the date of the appellate review, the Chief Executive Officer shall send the Practitioner Special Notice setting forth the time, place and date of the review. The Appellate Review Body may extend the time for the appellate review for good cause, and if the request is made, as soon as is reasonably practicable.
- (d) Appellate Review Body: The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of three (3) or more members of the Board appointed by the chairperson of the Board. If a committee is appointed, one (1) of its members shall be designated as chairperson by the Board chairperson. The Appellate Review Body shall, in all circumstances, include a member of the Medical Staff appointed by the chairperson of the Board.

#### 12.11 Appellate Review Procedure.

- (a) Nature of Proceedings: The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee or hearing officer, the Hearing Committee or hearing officer's report, and all subsequent

results and actions thereof. The Appellate Review Body also shall consider any written statements submitted pursuant to Subsection 12.11(b) of this Article 12 and such other materials as may be presented and accepted under Subsections 12.11(c)(ii) and (iii) of this Article 12.

- (b) **Written Statements:** The Practitioner seeking the review shall, at least five (5) days prior to the scheduled date of the appellate review, submit to the Appellate Review Body (through the Chief Executive Officer), a written statement that describes the findings of fact, conclusions and procedural matters with which the Practitioner disagrees, and the reasons for such disagreement. The group whose adverse action occasioned the review may submit a written statement in support of the group's action and/or in reply to the Practitioner's statement. Any such statement by the group whose action occasioned the review shall be furnished to the Appellate Review Body at least two (2) days prior to the scheduled date of the appellate review. The Chief Executive Officer, on behalf of the Appellate Review Body, shall immediately forward a copy of the statement to the affected Practitioner. The Appellate Review Body in its sole discretion may waive the time limits provided in this Subsection 12.11(b) of Article 12. (c)

**Conduct of the Appellate Review:**

- (i) The chairperson of the Appellate Review Body shall preside over the appellate review, including determining the order of procedure, making all required rulings and maintaining decorum during all proceedings.
  - (ii) The Appellate Review Body may, at its discretion, allow the parties or their Representatives to appear and make statements. Parties or their Representatives appearing before the review body must answer questions posed to them by the review body.
  - (iii) If a party wishes to introduce new matters or evidence not raised or presented during the original hearing and not otherwise reflected in the record, the party may introduce such information at the appellate review only if expressly permitted by the review body in its sole discretion and only upon a showing by the party requesting consideration of the information that it could not have been discovered in time for the initial hearing. Prior to introduction of such information at the review, the requesting party shall provide, to the Appellate Review Body and the other party, a written, substantive description of the information.
- (d) **Presence of Members and Vote:** A majority of the review body shall be present at all times during the review and deliberations. If a review body member is absent from any part of the review or deliberations, the chairperson of the review body, in the chairperson's discretion, may rule that such member be excluded from further participation in the review or deliberations or in the recommendation of the review body.
  - (e) **Recesses and Adjournments:** The Appellate Review Body may recess the review proceeding and reconvene the same without additional notice if it deems such recess necessary for the convenience of the participants or to obtain new or additional evidence or consultation required for resolution of the matter. When oral statements (if allowed) are complete, the appellate review shall be closed. The review body shall then deliberate outside the presence of the parties at such time and in such location as is convenient to

the review body. The appellate review shall be adjourned at the conclusion of those deliberations.

- (f) **Action Taken:** The Appellate Review Body may recommend that the Board affirm, modify or reverse the adverse result or action or, in its discretion, may refer the matter back to the Hearing Committee or hearing officer for further review and recommendation to be returned to it within ten (10) days and in accordance with its instructions. Within five (5) days after receipt of such recommendation after referral, the review body shall make its recommendation to the Board as provided in this Subsection 12.11(f) of Article 12.

12.12 **Final Decision of the Board.** Within forty-five (45) days after receipt of the Appellate Review Body's recommendation, the Board shall render its final decision in the matter in writing and shall send notice thereof to the affected Practitioner and to the Chief of Staff. The Board's final decision shall be immediately effective, and the matter shall not be subject to any further referral or review.

12.13 **Reporting.** The Chief Executive Officer shall report any final action taken by the Board pursuant to these Bylaws to the appropriate authorities as required by law and in accordance with applicable Hospital procedures regarding the same.

12.14 **General Provisions.**

- (a) **Waiver:** If at any time after receipt of notice of an adverse recommendation, action or result, the affected Practitioner fails to make a required request or appearance or otherwise fails to comply with this Article 12, the Practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which the Practitioner might otherwise have been entitled with respect to the matter involved and the adverse action or recommendation shall become a final action.
- (b) **Exhaustion of Remedies:** Any Applicant or member of the Medical Staff must exhaust the remedies afforded by this Article 12 before resorting to any form of legal action.
- (c) **Release:** By requesting a hearing or appellate review under these Bylaws, a Practitioner or Applicant agrees to be bound by the provisions of these Bylaws relating to immunity from liability.

## **ARTICLE 13 - CONFIDENTIALITY, REPORTING IMMUNITY AND RELEASES**

13.1 **Special Definitions.** The following are special definitions applicable only to this Article 13:

- (a) **Information** means all communications, regardless of form, relating to the subject matter of Section 13.5 of this Article 13: Examples of such Information shall include, but not be limited to, the following: data, reports, records, minutes or other records of proceedings, memoranda, findings, recommendations, opinions, conclusions, actions, or forms whether written, oral, electronic, digital or in any other form or format. Such Information may include but is not limited to any matter that directly or indirectly affects the quality, appropriateness or efficiency of patient care by a Provider, including, but not limited to, a Provider's professional qualifications and judgment, clinical ability, character and professional ethics, mental and physical health, and utilization patterns.

- (b) **Malice** means actual knowledge of the falsity of statements or information or reckless disregard for the truth in making statements or disseminating Information.
- (c) **Provider** means any Practitioner or AHP who has, or has applied for, Medical Staff membership or Clinical Privileges at the Hospital.
- (d) **Third Parties** means any person (including organizations as well as individuals) who provides Information to any Representative.

13.2 Authorizations and Conditions. Submission of an Application for Staff membership or for the exercise of Clinical Privileges or the provision of patient care services in this Hospital constitutes a Provider's express:

- (a) Authorization for Hospital Representatives and the Medical Staff to request, provide and/or act upon Information bearing on the Provider's professional competency, conduct and qualifications;
- (b) Agreement to be bound by the provisions of these Bylaws (including this Article 13), Medical Staff Rules and Regulations, Hospital's Bylaws, Hospital's policies and procedures, and Hospital's Corporate Compliance Plan, and to waive all legal claims against any Hospital Representative who acts in accordance with such provisions, including the provisions of this Article 13; and
- (c) Acknowledgment that the provisions of this Article 13 are express conditions to Provider's Application for, acceptance of, and continuation of Staff membership, and to Provider's exercise of Clinical Privileges at Hospital.

13.3 Confidentiality of Information. The following Information shall, to the fullest extent permitted by law, be confidential and shall not be disclosed or disseminated except to a Representative or used in any way except as permitted in these Bylaws and as allowed by applicable law. Information relating to a Provider that is collected, prepared or submitted by a Representative of the Hospital or any other hospital or health care organization or facility or Medical Staff for the purpose of monitoring, evaluating or improving the quality of health services; determining that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care; evaluating the qualifications, competence and performance of health care Providers or acting upon matters relating to the discipline of a health care Provider; reducing morbidity or mortality; evaluating the quantity, quality and timeliness of health care Services rendered; and conducting research, or teaching, establishing or enforcing guidelines designed to keep costs of health care within reasonable bounds. Similarly, such Information provided by Third Parties shall be confidential to the extent permitted by law. No such Information shall be considered a part of or be included in any patient record. Each Provider acknowledges that violation of the confidentiality provided for in this Article 13 shall be grounds for revocation of Staff membership and Clinical Privileges.

13.4 Immunity from Liability.

- (a) For Action Taken: Representatives of the Hospital or Medical Staff shall be immune from liability to a Provider for damages or other relief for such Representatives' actions, statements, recommendations, opinions, decisions or other conduct performed within the scope of their duties as a Representative, if such Representatives act in good faith and without malice after reasonable effort under the circumstances to ascertain the

truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

- (b) For Providing Information: Representatives of the Hospital or Medical Staff and Third Parties shall be immune from liability to a Provider for damages or other relief for providing Information, even if such Information would otherwise be privileged or confidential, to a Representative of this Hospital or Medical Staff or to any other health care facility or organization concerning a Provider, provided that such Information is related to the scope of the Representative's Peer Review Committee, related to the performance of the duties and functions of the recipient, and is reported in a factual manner; and further provided that the Representative or Third-Party acts in good faith and without Malice.

13.5 Activities Covered. The confidentiality and immunity provided by this Article 13 apply to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility's or organization's credentialing, peer review, performance improvement/quality assurance and utilization review activities including, but not limited to:

- (a) Applications for appointment or Clinical Privileges;
- (b) Applications for reappointment or addition or renewal of Clinical Privileges;
- (c) Corrective, supervisory or disciplinary action;
- (d) Hearings and appellate reviews;
- (e) Performance improvement/quality assurance activities;
- (f) Utilization review and utilization management activities;
- (g) Profiles and profile analysis;
- (h) Risk management activities; and
- (i) Any other Hospital, committee, Service or Staff activities related to evaluating, monitoring and maintaining quality and efficient patient care and professional conduct.

13.6 Releases. Upon request of the Hospital, each Provider shall execute general and specific releases in accordance with this Article 13. Such releases will operate in addition to the provisions of this Article 13 and execution of such releases shall not be a prerequisite to the effectiveness of this Article 13.

13.7 Cumulative Effect. Any provisions in these Bylaws and in the Application or other Hospital or Staff forms relating to authorizations, confidentiality of information and immunities from liability are in addition to, and not in limitation of, other protections provided by applicable law.

## **ARTICLE 14 - GENERAL PROVISIONS**

14.1 Staff Rules and Regulations. The Medical Staff shall adopt such Rules and Regulations as necessary to implement the general principles set forth in these Bylaws. Any such Rules and

Regulations shall be subject to Board approval. The Medical Staff shall follow the procedures outlined in Article 14 of these Bylaws in the adoption and amendment of the Rules and Regulations, except that Medical Staff action may occur by a majority vote at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by majority vote of those present who are eligible and qualified to vote.

- (a) If the Medical Executive Committee proposes to adopt a Rule and Regulation, or an amendment thereto, it must first distribute the proposal to the Medical Staff for review and comment.
- (b) When the Medical Executive Committee adopts a policy or amendment, it must communicate such action to the Medical Staff in writing.
- (c) A policy of the Medical Staff may be proposed to the Board without prior approval of the Medical Staff.
- (d) Rules and Regulations and policies of Medical Staff may be proposed by a signed petition of Fifty percent (50) of the Medical Staff or approved by the majority vote of the Medical Staff. Such proposed Rules and Regulations and policies of the Medical Staff shall be submitted to the Medical Executive Committee for review and opinion prior to submission to the Board for approval. The comments of the Medical Executive Committee may be submitted to the Board with the approved rule, regulation or policy.

14.2 Urgent Amendment to Rules and Regulations. An urgent amendment of the Rules and Regulations may be provisionally adopted where the Medical Executive Committee has a documented belief that the amendment is necessary to comply with a law or regulation. Following adoption by the Medical Executive Committee, the urgent amendment must be provisionally approved by the Board. The urgent amendment shall be provided immediately to the Medical Staff. If objection from the Medical Staff is not received by the Medical Executive Committee within Seven (7) days such amendment shall become final. If, however, the Medical Staff objects to the urgent amendment within the time specified above, such amendment shall not be final and may be submitted to the conflict resolution process described in Section 14.3 of this Article 14.

14.3 Management of Conflicts Between the Medical Staff and the Medical Executive Committee. A Conflict Resolution Committee shall be formed to resolve any conflict arising between the Medical Executive Committee and a group comprised of at least \_\_\_\_\_ percent (\_\_\_%) of the members of the Medical Staff entitled to vote.

- (a) The Conflict Resolution Committee shall be an ad hoc committee and shall consist of at least \_\_\_\_\_ (\_\_\_) members, including equal representation from the Medical Executive Committee and the group of Medical Staff members. The Committee may include a third-party facilitator as determined necessary by the Committee members or the Chief Executive Officer.
- (b) The authority of the Conflict Resolution Committee shall be limited to resolution of disputes related to Medical Staff rules, regulations and policies.
- (c) If the Conflict Resolution Committee is able to come to an agreement with regards to the disputed rule, regulation or policy, such agreement shall be submitted to the Board for approval.

- (d) If, after good faith efforts to resolve the dispute have been exhausted, the Committee is unable to reach agreement, the unresolved portions of the rule, regulation or policy shall be submitted to the Board for final decision.
  - (e) Nothing in this conflict resolution procedure is intended to prevent the Medical Staff from proposing a rule, regulation or policy directly to the Board.
- 14.4 Physician Health. The Medical Staff Rules and Regulations shall include policies and procedures to identify and manage matters of individual Physician health. The policies and procedures shall be designed to (either through internal processes or by referral to an impaired provider program approved by the Hospital Board provide education about Physician health; address prevention of physical, psychiatric or emotional illness; and facilitate confidential diagnosis, treatment and rehabilitation of Physicians who suffer from a potentially impairing condition. If at any time a Physician's health renders the Physician unable to safely perform the Physician's Privileges, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action.
- 14.5 Services. Subject to the approval of the Medical Executive Committee and the Board, each Service will formulate its own written policies, if any, as needed for the conduct of its affairs and the discharge of its responsibilities.
- 14.6 Corporate Compliance. To ensure that its business practices are conducted with the highest of ethical standards, Hospital has adopted a Corporate Compliance Plan (the "Plan"). This Plan generally requires the conduct of business in compliance with all applicable laws, regulations and standards and provides that any possible violations be reported to the Compliance Officer. The Practitioners and AHPs acknowledge and agree that, in performance of their duties, they are expected to follow these same standards and to report to the above-designated persons any possible violations of laws, regulations, standards or acceptable business practices.
- 14.7 Conflicts of Interest. Each Medical Staff Member shall disclose in writing on an annual basis any potential conflicts of interest (including any ownership or contractual interest the Practitioner or Practitioner's immediate family members may have with the Hospital or its related entities, suppliers, vendors or contractors) that the Staff Member may have with the Hospital or its related entities, consistent with the Hospital's conflict of interest policy.
- 14.8 Staff Dues. The Medical Executive Committee, with the approval of the Active Staff, will establish the amount and manner of disposition of annual dues, if any. Dues are payable at the beginning of each new Medical Staff year. Failure, unless excused by the Medical Executive Committee for good cause, to render payment within two (2) months of the start of the new Staff year shall, after Special Notice of the delinquency, result in automatic suspension of Staff membership (including all Prerogatives) and Clinical Privileges until the delinquency is remedied. The Medical Executive Committee, applicable Physician Coordinators and organizational components on which the delinquent Practitioner holds membership will be notified of the suspension.

#### **ARTICLE 15 - ADOPTION AND AMENDMENT OF BYLAWS**

- 15.1 Medical Staff Authority and Responsibility. Because the Board has delegated to the Medical Staff the authority and responsibility to initiate and recommend to the Board the Bylaws and related protocols establishing the Staff's organizational structure, and governing its processes and

manner of acting, subject only to certain limitations detailed in the Board's Bylaws, the adoption and amendment of these Bylaws require the actions specified in Sections 15.2 and 15.3 of this Article 15.

- 15.2 **Medical Staff Action.** Action or amendment of the Bylaws shall require the affirmative vote of Fifty (50%) of the Staff members eligible and qualified to vote on Bylaws, cast at a regular or special Staff Meeting. A copy of the proposed documents or amendments must be given to each Staff Member entitled to vote thereon with the Notice of the meeting. The Medical Staff's action shall be forwarded to the Board for its action.
- 15.3 **Board Approval.** Medical Staff recommendations regarding adoption or amendment of Bylaws are effective upon the affirmative vote of a majority of the members of the Board.
- 15.4 **Conflict Resolution.** When the Board disapproves a Bylaw or Bylaw amendment presented by the Medical Staff or proposes to adopt or amend Medical Staff Bylaws and such Bylaw or Bylaw amendments are contrary to Medical Staff recommendations, the Board shall submit the Bylaw or Bylaw amendment to the Medical Staff for consideration.
- (a) If the Bylaw or Bylaw amendment is approved by the affirmative vote of the majority of the Medical Staff, the Bylaw or Bylaw amendment shall be effective upon such date.
  - (b) If the Medical Staff does not approve the proposed Bylaw or Bylaw amendment, the approved Bylaw or Bylaw amendment shall be returned to the Board for consideration. The Board may either approve the Bylaw or Bylaw amendment, refer the Bylaw or Bylaw amendment to a Joint Conference Committee comprised of members of the Board and the Medical Executive Committee, or follow the conflict resolution process as provided in the Board Bylaws. If submitted to a Joint Conference Committee, the Committee's recommendation must be presented to the Board and Medical Staff for approval.

ADOPTED by the Medical Staff on \_\_\_\_\_, 2\_\_\_\_\_.

\_\_\_\_\_

Chief of Staff

APPROVED by the Board of Trustees [Trustees] on \_\_\_\_\_, 2\_\_\_\_\_.

\_\_\_\_\_  
Chairperson, Board of Trustees [Trustees]

**MEDICAL STAFF RULES &**

**REGULATIONS OF**

**THE CLINTON HOSPITAL AUTHORITY  
D/B/A CLINTON REGIONAL HOSPITAL**

**Adopted:**

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**RULES AND REGULATIONS  
OF THE MEDICAL STAFF  
OF  
CLINTON REGIONAL HOSPITAL**

**ARTICLE 1  
GENERAL**

- 1.1 Capitalized terms used in these Rules and Regulations shall have the same meaning as such terms in the Medical Staff Bylaws.
- 1.2 Each Physician who is an Active Member of the Medical Staff has a continuous duty to designate another Active Member of the Medical Staff who has equivalent Privileges to be the Physician's official alternate. In case of unavailability of such alternate, the Chief of the Medical Staff shall have the authority to call any Member of the Medical Staff should it be considered necessary.
- 1.3 The meetings of the Medical Staff shall be held at least quarterly or as otherwise provided in Article 10 of the Medical Staff Bylaws. One (1) meeting shall be considered an annual meeting for election of officers.
- 1.4 Regular meetings of the Medical Staff will be held to review the work, reports and recommendations of the Medical Staff and its committees and to complete Medical Staff administrative duties. The Medical Staff also will encourage educational programs.
- 1.5 A Physician shall be on-duty or on-call at all times. The Medical Staff shall participate in on-call coverage according to policies established by the Medical Staff and the Hospital Administration. Physicians shall comply with the EMTALA Rules and Regulations as outlined herein.
- 1.6 The Hospital maintains Disaster Programs for both the handling of mass casualties arising from external disasters and for internal disasters such as fire. All Medical Staff members shall participate in these Disaster Programs as assigned by the Chief of Staff and as otherwise specified in the program documents. These programs shall be reviewed at least once a year by key Hospital personnel.
- 1.7 The Medical Staff shall participate in Hospital performance improvement activities to improve the quality of care, treatment and Services, and patient safety. Medical Staff Members shall participate in the development and implementation of these activities as required in related Hospital policies.
- 1.8 The Medical Staff shall abide by Hospital's infection control and safety policies to enable the administration to protect patients from contagious disease or to protect the patients from self-harm.

**ARTICLE 2  
PROVISION OF PATIENT CARE**

**2.1 Admission to Care**

- (a) Authority to admit and supervise treatment of patients is exclusively delegated to Practitioners with status and Privileges required by the Medical Staff Bylaws for admission and treatment of patients. The admitting Practitioner must be in Good Standing under the Medical Staff Bylaws.

- (b) If a patient is admitted by a Practitioner other than a Physician, the Practitioner must designate a Physician who has agreed to oversee the medical care provided to the patient.
- (c) A provisional diagnosis, justification of admission and continued hospitalization, patient's progress, and response to medications and Services must be recorded on all medical records. Where provision of diagnosis is delayed due to emergency, the provisional diagnosis shall be given as soon after admission as possible.

## 2.2 Medical Necessity and Utilization Review

- (a) The admitting Practitioner is responsible for deciding whether the patient should be admitted as an inpatient or receive Services as an outpatient. If the admitting Practitioner expects that the patient will require hospital care for at least two (2) midnights, inpatient admission may be appropriate. The decision to admit a patient is a complex medical judgment, which can be made only after the Practitioner has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the Hospital's Bylaws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as: the severity of the signs and symptoms exhibited by the patient, the medical predictability of something adverse happening to the patient, the need for diagnostic studies that appropriately are outpatient Services (i.e., their performance does not ordinarily require the patient to remain at the Hospital for twenty-four (24) hours or more) to assist in assessing whether the patient should be admitted, and the availability of diagnostic procedures at the time when, and at the location where, the patient presents.
- (b) The admitting Practitioner is responsible for completing documentation sufficient to support the medical necessity for an inpatient admission. Documentation also should support the clinical indications for diagnostic tests and treatments ordered by the Practitioner.
- (c) The Hospital has a Utilization Review Committee responsible for reviewing the medical necessity of admissions to the Hospital, duration of stays and professional Services furnished, including drugs and biologicals. Practitioners are expected to cooperate with the Utilization Review Committee to ensure medically appropriate treatment and efficient use of Hospital resources in the provision of patient care.

## 2.3 Coordination of Care

- (a) A patient's general medical condition shall be managed and coordinated by a Physician, provided that a Psychologist, Podiatrist or AHP with appropriate Clinical Privileges may manage and coordinate such care to the extent permitted under the Medical Staff Bylaws, relating to Prerogatives of Practitioners and AHPs and to the extent to which such care is within the scope of practice of the Practitioner or AHP, as permitted by Oklahoma law.
- (b) Every patient must be assessed and reassessed at an interval appropriate to address the medical needs of the particular patient. Patients shall be seen at least once a day by the attending Practitioner or a qualified designee, and documentation of such assessment will be entered in the medical record.

- (c) Where the admitting Practitioner transfers care to the control and supervision of another Practitioner, such transfer must be clearly documented in the patient's medical record.

#### 2.4 Radiologic Services

- (a) The Radiology Department and all radiology patient Services shall be under the supervision of a designated Medical Staff Physician who is a Radiologist. Whenever possible, this Physician shall be an attending or consulting Radiologist.
- (b) Use of radiology equipment and administration of radiology procedures is limited to personnel considered qualified per requirements established with the approval of the Medical Staff.
- (c) The interpretation of all radiologic examinations shall be made by Physicians qualified by education and experience in radiology. A written report of the findings and evaluation of each radiological examination performed, or course of treatment conducted, shall be signed by the Physician responsible for the procedure and shall be made a part of the patient's permanent medical record. Fluoroscopy shall be conducted by, or under the direct supervision of, a Physician.

#### 2.5 Consultation

- (a) A consultant must be a Member of the Medical Staff with appropriate Clinical Privileges and qualified to give an opinion in the field in which the consultant's opinion is sought.
- (b) A consultation request may be appropriate in the following circumstances:
  - (i) Any time the nature of the outcome is not clear or diagnosis is obscure;
  - (ii) The problem is outside the normal scope of practice of the Practitioner;
  - (iii) Anticipated treatment requires a Practitioner with Privileges in the specialty to properly manage or treat the patient;
  - (iv) In cases in which the patient exhibits severe psychiatric symptoms, including drug overdose and attempted suicide, except when the attending is a Psychiatrist;
  - (v) When the patient does not respond to conventional treatment or is a poor risk for operation or treatment; or
  - (vi) When requested by the patient or the patient's family.
- (c) The order for a consultation must be documented in the patient's medical record.
- (d) The consultant must respond to a consultation request within a reasonable amount of time, taking into account whether the consultation request is urgent or routine.
- (e) The consultant shall communicate all findings to the referring Practitioner and document the consultation in the patient's medical record. Such documentation must evidence a review of the patient's record by the consultant, describe pertinent findings

on examination of the patient, and provide the consultant's opinion and recommendations. A limited statement such as "I concur" is not an acceptable report of consultation. When operative procedures are involved, the consultation notes shall, except in emergency situations, be recorded prior to the operation.

## 2.6 Surgical and Anesthesia Services

- (a) A roster of Medical Staff Members with surgical Privileges shall be maintained in the surgical suite and available to the surgical nurse supervisor.
- (b) Except in cases of extreme emergency, a study of the patient shall be completed and recorded before inpatient surgery. This study shall include: complete history, physical examination and recording of the preoperative diagnosis, as well as appropriate laboratory work. If not recorded, the surgery will be deferred. Patient studies for outpatient surgery will be handled according to Hospital's policies and procedures, as amended from time to time.
- (c) Surgical assistants may be used at the discretion of the operating surgeon. All surgical assistants must either have applicable Clinical Privileges at Hospital or, if not within a category of AHP-provided Clinical Privileges, be approved otherwise by the Hospital to provide patient care.
- (d) Written, signed, informed consent shall be obtained by the operating surgeon prior to the operative procedure, except in those situations wherein the patient's life is in jeopardy, and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained in the medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.
- (e) All tissues removed during an operation shall be the property of the Hospital and shall be examined by a competent Physician whose report shall form a part of the patient's medical record.
- (f) All tissues removed shall be macroscopically examined. If deemed necessary by written Hospital policies and procedures, tissues shall then be microscopically examined.
- (g) There shall be a director of anesthesia that shall be responsible for all anesthetics administered. Anesthesia shall be administered only by a qualified individual with appropriate Clinical Privileges at Hospital and licensure from the state of Oklahoma.
- (h) Each patient requiring anesthesia shall have a pre-anesthesia evaluation by a Physician regarding the choice of anesthesia. This evaluation must be performed within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia Service.
- (i) Each patient's condition shall be reviewed immediately prior to induction. This shall include a review of the patient's medical record with regard to completeness of pertinent laboratory data and an appraisal of any changes in the condition of the patient as compared with that noted on the patient's medical record.
- (j) Following the procedure for which anesthesia was administered, the anesthetist or a designee shall remain with the patient as long as required by the patient's condition

relative to the patient's anesthesia status and until responsibility for proper patient care has been assumed by other qualified individuals. A post anesthesia evaluation, completed and documented by the individual qualified to administer anesthesia, must be completed no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services.

## 2.7 **Dental Services**

- (a) In order to be granted Clinical Privileges in dentistry and/or oral and maxillofacial surgery, a Dentist shall complete the initial Application process as outlined in the Medical Staff Bylaws.
- (b) Oral and maxillofacial surgeons may perform the medical history and physical examination, to the extent that they have such Clinical Privileges in accordance with the Medical Staff Bylaws, in order to assess the medical, surgical and anesthetic risks of the proposed procedures.
- (c) Dentists may write orders and prescribe medications within the limits of their licensure and Clinical Privileges granted by the Medical Staff.

## 2.8 **Podiatry Services**

- (a) Podiatric Privileges shall be delineated pursuant to the Medical Staff Bylaws. Podiatrists with Clinical Privileges may provide consultation on the request of a Member of the Medical Staff.
- (b) Podiatric patients will be admitted by a Physician Member of the Medical Staff who shall be responsible for the pre-operative medical evaluation of the patient, care of any pre-existing or inter-current medical problems, and completion of the medical record planning discharge instructions. The Podiatrist may write orders directly related to the operative procedure.
- (c) The podiatric history and physical may be performed by the Podiatrist along with the operative report and post-operative progress record as permitted by the Medical Staff Bylaws. The Physician Member of the Medical Staff involved in the patient's care must provide appropriate documentation to supplement any record created by the Podiatrist. The Podiatrist shall complete all patient medical records in compliance with the Hospital's medical records, Rules and Regulations. The justification for the operative procedure shall be clearly delineated in the report.

## 2.9 **Psychologist Services**

- (a) In order to be granted Clinical Privileges in psychology, a Psychologist shall complete the initial Application process as outlined in the Medical Staff Bylaws.
- (b) All patients admitted to the Hospital by a Psychologist must also be under the care of a Physician Member of the Medical Staff.
- (c) A Psychologist may perform the medical history and physical examination, to the extent that the Psychologist has such Clinical Privileges in accordance with the Medical Staff Bylaws, in order to assess the psychological condition and treatment of the patient. An admitting history and physical shall be submitted or supplemented by a Physician Member of the Medical Staff who is selected by the Psychologist.

- (d) A Psychologist may write orders and prescribe medications within the limits of the Psychologist's licensure and Clinical Privileges granted by the Medical Staff.

#### 2.10 **Discharge from Care**

- (a) Patients shall be discharged only on the order of a Practitioner and, in the case of post-operative patients, by approved post-operative discharge criteria.
- (b) Discharge planning and evaluation shall begin at the time of admission. Patients who are likely to suffer adverse health consequences upon discharge, if there is no adequate discharge planning, must be identified. A registered nurse ("R.N."), social worker or other appropriately qualified personnel must develop or supervise the development of a discharge planning evaluation for such patients. Medical Staff shall support and coordinate discharge planning with Hospital Staff.

### **ARTICLE 3 MEDICAL RECORDS**

#### 3.1 **General**

- (a) Entries in the medical record are made only by authorized individuals. All entries must be dated, authenticated by the person making the entry and legible. At a minimum, medical records shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to accurately document the results accurately.
- (b) Each medical record shall include, at a minimum: admitting diagnosis; results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient; documentation of complications, Hospital acquired infections, and unfavorable reactions to drugs and anesthesia; properly executed informed consent forms for procedures and treatments specified by the Medical Staff, or by federal or state law if applicable, to require written patient consent; all Practitioners' or AHPs' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition; discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care; and final diagnosis.
- (c) In addition to the above listed elements, each inpatient medical record shall include a unique identifying record number; pertinent identifying and personal data; history of present illness or complaint; if injury, how the injury occurred; past history; and family history.
- (d) An appropriate record shall be maintained for every patient receiving emergency service and will be incorporated in the patient's medical record, if one exists. Its contents shall include patient identification, time and method of arrival, history, physical findings, treatment, and disposition. The emergency room record shall be signed by the Physician in attendance who is responsible for its clinical accuracy. This record shall be separate from and in addition to any centralized Emergency Services Log.
- (e) An appropriate record for outpatient observation (less than twenty-four (24) hours) shall be maintained.

- (f) Each medical record shall be treated as confidential in accordance with the Hospital's privacy and security policies for the protection of individually identifiable health information. Records may only be accessed by individuals authorized by Hospital policies and procedures.
- (g) Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In case of re-admission of a patient, all previous records shall be available for the use of the attending Physician. This shall apply whether the patient is attended by the same Physician or another Physician.
- (h) All Discharge Summaries shall identify the patient, and contain sufficient information to support the diagnosis, justify the treatment, document the course and results of the treatment, and permit adequate continuity of care among health care providers. Discharge Summaries also shall contain instructions given to the patient relating to physical activity, medication, diet and follow-up care.
- (i) Only abbreviations and symbols approved by the Medical Staff may be used in the medical records. Each abbreviation or symbol shall have only one (1) meaning, and an explanatory legend shall be available for use by all concerned. There shall be a list of abbreviations and symbols that shall not be used in handwritten communications.

### 3.2 History and Physical

- (a) A medical history and physical examination must be completed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to a surgery or a procedure requiring anesthesia Services. The medical history and physical examination must be placed in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia Services.
- (b) An updated history and physical examination must be completed and documented, including any changes in the patient's condition, when the medical history and physical examination are completed within thirty (30) days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia Services.
- (c) At minimum, the history and physical must include \_\_\_\_ [include required elements of the history and physical per Hospital policy].
- (d) An Advanced Practice Registered Nurse ("APRN") or Physician Assistant ("PA") with appropriate Clinical Privileges working in collaboration with a Physician may perform a history and physical examination. Physician shall co-sign the history and physical examination.

### 3.3 Operative Records

- (a) Pre-operative and post-operative medical records must be completed in an accurate and timely manner. An accurate and complete description of findings and techniques of operation shall be completed immediately after surgery, and the surgeon must enter a progress note in the patient's chart prior to transferring the patient to

the next level of care. The surgeon must dictate or hand write the operative report to be placed in the medical record immediately after surgery.

### 3.4 Anesthesia Records

- (a) The Anesthesia Department shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, inter-operative anesthesia and post-anesthetic follow-up of the patient's condition. The surgeon/Physician should note use of anticipated general, spinal or other regional anesthesia, and the Anesthesiologist or Anesthetist shall document the type of anesthesia administered on the anesthetic record.
- (b) A record of events taking place during the induction and maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions, shall be made.

### 3.5 Signature Requirements

- (a) All clinical entries in the patient's medical record shall be accurately dated and authenticated by the individual making the entry. The method of acceptable authentication used shall be either:
  - (i) Legible full signature;
  - (ii) Legible first initial and last name;
  - (iii) Illegible signature or initials over a typed or printed name;
  - (iv) Illegible signature or initials matching a signature log maintained on file by the Medical Records Department; or
  - (v) An electronic signature.
- (b) Where an authentication is made by electronic signature, the individual authenticating the record must have signed an electronic signature agreement agreeing to maintain the confidentiality and integrity of the username and password. Medical Staff Members found to be in violation of the Hospital's electronic signature policies may be subject to discipline under the Medical Staff Bylaws.
- (c) Use of rubber stamp signatures is strictly prohibited.
- (d) Where possible, authentication should be made at the time of the creation of the record. All authentication must be made within thirty (30) days of the creation of the record or as otherwise required by these Rules and Regulations or Hospital policy. Where authentication is not made within thirty (30) days, the individual authenticating the record must attest to the accuracy of the information utilizing Hospital approved attestation language.

### 3.6 Delinquent Records

- (a) Medical records are considered delinquent if they remain incomplete for more than thirty (30) days following the patient's discharge from the Hospital. Incomplete record items

include: missing dictation or reports, such as discharge summaries, history and physical examination records, operative reports, and consultations; unsigned dictation and reports; unsigned verbal orders; and other unsigned written entries in the chart (e.g. progress notes, post-operative notes and consents). In addition, history and physical examination records are considered delinquent if they are not dictated within twenty-four (24) hours of admission and operative reports are considered delinquent if they are not dictated immediately following the procedure. Medical records which are unavailable to the Practitioner or AHP, and remain incomplete for thirty (30) days following the patient's discharge, will not be considered delinquent.

- (b) The Practitioner or AHP whose records are delinquent will be notified via written notice that records must be completed within one (1) week from the date on which the notice is sent. If the records are not complete within one (1) week, admitting Privileges will be suspended.
- (c) Suspension of a Practitioner shall be interpreted in accordance with Subsection 11.11(c) of Article 11 of the Medical Staff Bylaws to mean that the Practitioner may not admit patients under the Practitioner's own or any other Practitioner's name during the period of suspension, may not provide consultation Services, and may not schedule surgeries or procedures. The suspended Practitioner will continue to be responsible for attending the Practitioner's own patients admitted to the Hospital prior to the suspension, proceed with patient surgeries/procedures scheduled prior to the suspension, deliver pregnancies as applicable, and provide evaluation and treatment of emergency cases at the request of the Chief Executive Officer or President of the Medical Staff. The suspended Practitioner also will be consulted regarding which alternate Practitioner should assume responsibility for admitting the suspended Practitioner's patient's to the Hospital during the period of suspension. The Practitioner's Privileges will be automatically reinstated upon completion of the delinquent records.

## **ARTICLE 4 ORDERS**

### **4.1 Medication and Treatment Orders**

- (a) Medication or treatment shall be administered only upon written and signed orders of a Practitioner or AHP who is acting within the scope of that Practitioner's or AHP's license and who is qualified according to the Medical Staff Bylaws.
- (b) Each Practitioner or AHP is responsible for the monitoring and review of the medications the Practitioner or AHP has ordered for a patient. Pharmacy Staff may periodically request a Practitioner or AHP review an order for continuation, and each Practitioner or AHP is expected to cooperate with such request.
- (c) Medication orders shall be written according to policies and procedures, and those written by persons who do not have independent statutory authority to prescribe shall be included in the quality improvement program.
- (d) Automatic stop orders for all medications shall be established and shall include a procedure to notify the prescriber of an impending stop order. A maximum stop order shall be effective for all medications which do not have a shorter stop order. Automatic stop orders are not required when the Pharmacist continuously monitors medications to ensure that the medications are not inappropriately continued.

- (e) Respiratory Services must only be provided under the orders of a qualified and licensed Practitioner or AHP who is responsible for the care of the patient and acting within the Practitioner's or AHP's scope of practice. All respiratory care orders must be documented in the patient's medical record. If an order for therapy is not adequate or explicit, further written explanation and instructions will be requested from the Practitioner or AHP.
- (f) The ordering Physician or independently licensed provider is not required to maintain Clinical Privileges at the Hospital to order outpatient Services. Certain outpatient services may require the ordering Physician or independently licensed provider to coordinate with a Practitioner or AHP who has appropriate Clinical Privileges to coordinate the outpatient Services to be provided.

#### 4.2 **Standing Orders**

- (a) All medication orders shall be written in the medical record and signed by the ordering Practitioner or AHP with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per Physician-approved Hospital policy/protocol after an assessment for contraindications. When medication therapy is based on a protocol or standing order and a specific medication order is not written, a signed copy of the protocol or of an abbreviated protocol containing the medication order parameters or of the standing order shall be placed in the medical record with the exception of Physician-approved policies/protocols for the administration of influenza and pneumococcal polysaccharide vaccines after an assessment for contraindications. The assessment for contraindications shall be dated and signed by the R.N. performing the assessment and placed in the medical record.
- (b) Hospitals may adopt policies and procedures that permit the use of standing orders to address well-defined clinical scenarios involving medication administration. An order that has been initiated for a specific patient must be added to the patient's medical record at the time of initiation, or as soon as possible thereafter. The Practitioner or AHP is responsible for acknowledging and authenticating all standing orders, with the exception of influenza and pneumococcal polysaccharide vaccines. When Hospital-based agreements, protocols or standing orders are used, they shall be approved by the pharmacy and therapeutics or equivalent committee.

#### 4.3 **Verbal Orders**

- (a) Telephone/verbal orders for medication or treatment shall be accepted only from authorized individuals when it is impractical for such orders to be given in writing. Telephone/verbal orders may be accepted by an R.N. or other person qualified and authorized under Hospital policy to accept such orders. All verbal orders shall include the name of the dictating Practitioner or AHP, the date and time the order was taken, and the name and signature of the authorized person transcribing the order.
- (b) Verbal/telephone orders shall include the date, time and signature of the person recording them. The prescribing or covering Practitioner or AHP shall authenticate the order within seventy-two (72) hours of the patient's discharge or within thirty (30) days, whichever occurs first.

#### 4.4 **Do Not Resuscitate Orders**

- (a) The patient has the right to accept medical care or to refuse it to the extent permitted by law and to be informed of the medical consequences of refusal. The patient has the right to appoint a surrogate to make health care decisions on the patient's behalf to the extent permitted by law. Each Practitioner or AHP is expected to cooperate with the patient's rights or notify Hospital if the request conflicts with the Practitioner's or AHP's personal belief or ethics.
- (b) Where a patient diagnosed with a terminal illness executes a Declaration directing the withholding or withdrawal of death-prolonging procedures, the patient's Physician is responsible for completing additional documentation required by Hospital policy. If the Physician refuses to comply with the directive, the Physician must transfer the care of the patient to another Physician on the Medical Staff.
- (c) If a conflict arises with a Do Not Resuscitate Order or Advance Directive, the issue may be directed to the Hospital Ethics Committee.

## **ARTICLE 5 ALLIED HEALTH PROFESSIONALS**

5.1 **Categories of AHP.** The Hospital currently credentials the categories of AHPs as provided in this Article 5. Other licensed health care professionals may provide patient care services at the Hospital as Hospital employees or under contract with the Hospital, but are not issued Privileges to provide clinical services to Hospital patients independently. All Privileges extended to AHPs must be provided consistent with the Medical Staff Bylaws.

### 5.2 **Advanced Practice Registered Nurse**

- (a) An Advanced Practice Registered Nurse "APRN" may provide services to a Hospital inpatient or outpatient under a collaborative practice agreement that complies with the provisions of Oklahoma law. If the collaborating Physician is not on the Hospital's Medical Staff, the APRN must have a Physician on the Medical Staff serve as a sponsor for supervision of Hospital patients.
- (b) An APRN may order diagnostic tests and therapies at Hospital consistent with the APRN's licensure and collaborative practice agreement. An APRN only may order medications to the extent authorized under the collaborative practice agreement. To order controlled substances, the APRN must have appropriate authority under the collaborative practice agreement and hold a current BNDD and DEA registration.
- (c) A separate privileging form is maintained for APRNs, and an APRN only may be granted privileges for services designated on the APRN privileging form.

### 5.3 **Chiropractor**

- (a) For a Chiropractor to provide Services to a Hospital inpatient or outpatient, the patient must be under the medical care of a Physician on the Hospital's Medical Staff.
- (b) The Hospital may provide outpatient Services to a patient on the order of a Chiropractor so long as the order is within the scope of practice of the Chiropractor. The Hospital may designate outpatient services that require the order of a Chiropractor to include designation of the Physician responsible for the medical care of the patient.

- (c) A separate privileging form is maintained for Chiropractors and a Chiropractor only may be granted Privileges for services designated on the Chiropractor privileging form.

#### 5.4 **Certified Registered Nurse Anesthetist**

- (a) A Certified Registered Nurse Anesthetist “CRNA” is a qualified anesthesia provider in the Hospital. A CRNA may be granted Privileges relating to the provision of anesthesia, including pre- and post-anesthesia care.
- (b) Both the CRNA and the attending surgeon are responsible for ensuring that the procedure and the level of anesthesia to be administered are within the scope of Services for which the surgeon is credentialed to perform and supervise.
- (d) A CRNA in collaboration with a medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state, and under conditions in which timely on-site consultation by such medical doctor, osteopathic physician, podiatric physician or dentist is available, shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in the preanesthetic preparation and evaluation, anesthesia induction, maintenance and emergency, and post-anesthesia care. A CRNA may order select, obtain, and administer drugs only during the perioperative or peri-obstetrical period. As used in this section, “collaboration” means an agreement between a medical doctor, osteopathic physician, podiatric physician, or dentist performing the procedure or directly involved with the procedure and the CRNA working jointly toward a common goal providing services for the same patient. This collaboration involves the joint formulation, discussion and agreement of the anesthesia plan by both parties, and the collaborating medical doctor, osteopathic physician, podiatric physician or dentist performing the procedure or directly involved with the procedure and that collaborating physician shall remain available for timely onsite consultation during the delivery of anesthesia for diagnosis, consultation, and treatment of medical conditions.
- (c) A separate privileging form is maintained for CRNAs, and a CRNA may only be granted Privileges for Services designated on the CRNA privileging form. The Hospital has adopted an umbrella CRNA Collaborative Agreement that each CRNA will execute with the Physician Chief of Staff in conjunction with the employment and/or credentialing process at the Hospital.

#### 5.5 **Anesthesia Assistant**

- (a) An Anesthesia Assistant (“A.A.”) is a qualified anesthesia provider in the Hospital. An A.A. may be granted privileges relating to the provision of anesthesia, including pre- and post-anesthesia care, to the extent such Services are within the delegation by a licensed Anesthesiologist.
- (b) An A.A. may only provide services in the Hospital under the delegation of an Anesthesiologist. An Anesthesiologist must be immediately available at all times during which the A.A. is providing Services.
- (c) A separate privileging form is maintained for A.A.s, and an A.A. may only be granted Privileges for Services designated on the A.A. privileging form.

#### 5.6 **Optometrist**

- (a) For an Optometrist to provide services to a Hospital inpatient or outpatient, the patient must be under the medical care of a Physician on the Hospital's Medical Staff.
- (b) The Hospital may provide outpatient services to a patient on the order of an Optometrist so long as the order is within the scope of practice of the Optometrist. The Hospital may designate outpatient services that require the order of an Optometrist to include designation of the Physician responsible for the medical care of the patient.
- (c) A separate privileging form is maintained for Optometrist and an Optometrist may only be granted Privileges for Services designated on the Optometrist privileging form.

## 5.7 **Physician Assistant**

- (a) A Physician Assistant ("P.A.") may provide Services to a Hospital inpatient or outpatient under a Physician supervision agreement with a Physician on the Hospital's Medical Staff. The P.A.'s supervising Physician must be available in person or by phone at all times during which the P.A. provides patient care Services at the Hospital.
- (b) The Services provided by a PA are limited to:
  - (i) Taking patient histories;
  - (ii) Performing physical examinations of a patient;
  - (iii) Performing or assisting in the performance of routine office laboratory and patient screening procedures;
  - (iv) Performing routine therapeutic procedures;
  - (v) Recording diagnostic impressions and evaluating situations calling for attention of a Physician to institute treatment procedures;
  - (vi) Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a Physician;
  - (vii) Assisting the supervising Physician in institutional settings, including reviewing of treatment plans, ordering of tests and diagnostic laboratory and radiological Services, and ordering of therapies, using procedures reviewed and approved by Physician;
  - (viii) Assisting in surgery;
  - (ix) Performing such other tasks not prohibited by law under the supervision of a Physician as the P.A. has been trained, is proficient to perform and has been granted applicable Clinical Privileges; and
  - (x) Prescribing drugs only to the extent permitted under the Physician supervision agreement. Any controlled substances may only be prescribed as permitted under the Physician supervision agreement and the P.A.'s BNDD and DEA registration.
- (c) Subject to the limitations in Subsection (b), a P.A. may order diagnostic tests and therapies at Hospital consistent with the P.A.'s licensure and physician supervision agreement. A P.A. may only order medications to the extent authorized under the Physician supervision

agreement. To order controlled substances, the P.A. must have appropriate authority under the Physician supervision agreement and hold a current BNDD and DEA registration.

- (d) A separate privileging form is maintained for P.A.s, and a P.A. may only be granted Privileges for Services designated on the P.A. privileging form.

## **ARTICLE 6 RESTRAINTS AND SECLUSION**

6.1 **Patient Rights.** All patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from restraint or seclusion of any form, imposed as a means of coercion, discipline, convenience or retaliation by Staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, Hospital personnel, Staff Members or others, and must be discontinued at the earliest possible time. Restraint or seclusion shall never be used as a punishment or for the convenience of the staff.

- (a) The term “restraint” includes either a physical restraint or a drug that is being used as a restraint.
- (b) A physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the patient’s body that the patient cannot easily remove that restricts freedom of movement or normal access to one’s body.
- (c) A drug used as a restraint is a medication used to control behavior or to restrict the patient’s freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition.
- (d) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressing or bandages, protective helmets, or other methods, that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- (e) "Seclusion" is the involuntary isolation of a patient alone in a room where the patient's freedom to leave is restricted.

6.2 **Use of Restraints or Seclusion.** Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, Hospital personnel or others from harm. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, Hospital personnel or others from harm.

6.3 **Physician Order.** Use of restraint or seclusion must be in accordance with the order of a Physician with appropriate Clinical Privileges under the Medical Staff Bylaws. The order for restraint or seclusion must be:

- (a) Followed by consultation with the patient’s treating Physician, as soon as possible, if restraint or seclusion is not ordered by the patient’s treating Physician;
- (b) In accordance with a written modification to the patient’s plan of care;
- (c) Signed within one (1) hour of implementation;

- (d) Implemented in the least restrictive manner possible;
- (e) In accordance with safe and appropriate restraining techniques; (f)

Ended at the earliest possible time; and

- (g) Time limited and never written as a standing order or on a PRN basis.

6.4 **Renewal of Order.** The order may only be renewed in accordance with the following limits for up to a total of twenty-four (24) hours:

- (a) three (3) hours for adults eighteen (18) years of age and older;
- (b) two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; (c) one (1) hour for children under nine (9) years of age; or
- (d) after twenty-four (24) hours, before writing a new order for the use of restraint or seclusion, the Physician responsible for the care of the patient must see and assess the patient.

6.5 **Face-to-Face Evaluation.** When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of a patient, Hospital personnel or others, the patient must be seen face-to-face within one (1) hour after the initiation of restraint or seclusion by a Physician, APRN, a licensed independent Practitioner, R.N. or P.A./ who has been trained on the restraint and seclusion policies and is approved by the Medical Staff for such evaluation. The evaluation must include the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion. If the face-to-face evaluation is performed by an APRN, R.N. or P.A., such individual must consult the attending Physician as soon as possible following the completion of the examination.

6.6 **Monitoring.** The condition of the patient who is restrained or secluded must be monitored by a Physician, other licensed independent Practitioner or trained Staff. Such monitoring of the patient's condition shall be at a frequency determined by the treating Physician, which shall be no less than once per each fifteen (15) minutes.

6.7 **Documentation.** Documentation must be present showing that the patient is in danger to the patient and/or others. Specifically, when restraint or seclusion is used, there must be documentation in the patient's medical record of the following: (i) the one (1)-hour face- to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior; (ii) a description of the patient's behavior and the intervention used; (iii) alternatives or other less-restrictive interventions attempted (as applicable); (iv) the patient's condition or symptoms(s) that warranted the use of the restraint and seclusion; (v) the patient's response to the interventions(s), including the rationale for continued use of the intervention; and (vi) the reason for the restriction, and the time of starting and ending the restriction. Nursing notes should reflect the continuous monitoring of the secluded or restrained patient. A Physician must sign a statement explaining the necessity for the use of any restraint or seclusion and shall make such statement part of the patient's permanent medical records.

6.8 **Simultaneous Restraint and Seclusion.** Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored (i) face-to-face by an assigned, trained Staff Member; or (ii) by trained Staff using both video and audio equipment in close proximity to the patient.

- 6.9 **Intake and Output.** Patients must have the opportunity for regular meals, adequate fluids and use of the bathroom.
- 6.10 **Training.** Physicians and other Hospital personnel shall complete training on use of restraints and seclusion as required under Hospital Policy.

## ARTICLE 7 EMERGENCY SERVICES

- 7.1 **Organization.** Emergency Services shall be organized under the direction of a qualified member of the Medical Staff and shall be integrated with other Departments of the Hospital. The duties of the directing member of the Medical Staff shall be adopted by the Governing Body.
- 7.2 **On-Call Coverage.** Medical Staff Members, including specialists and sub-specialists, are required to participate in on-call coverage as determined necessary by Hospital and in accordance with the Medical Staff Bylaws.
- 7.3 **Response Time.** On-call Practitioners shall respond within a reasonable period of time after receiving a page or telephone call from emergency personnel. Surgeons assigned to emergency surgery call coverage must be available to arrive at the Hospital within thirty (30) minutes of being summoned.
- 7.4 **Screening Examination.** The Hospital will provide an appropriate medical screening examination within its capability, including ancillary Services routinely available to the Emergency Department, for persons (who are not already inpatients) on the Hospital's property requesting examination for what might be an emergency medical condition.
- (a) An "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency medical condition exists if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.
  - (b) The "Hospital's property" means the entire main Hospital campus, including the parking lot, sidewalk and driveway, but excluding other areas or structures of the Hospital's main building that are not part of the Hospital, such as Physician offices, rural health centers, skilled nursing facilities or other entities that participate separately under Medicare, as well as restaurants, shops or other nonmedical facilities.
  - (c) The screening examination may be performed by Medical Staff Practitioners, emergency room Physicians, emergency room Registered Professional Nurses, and labor and delivery Registered Professional Nurses. Psychiatric patients will be screened by individuals qualified by training and experience, including Physicians, psychiatric Registered Professional Nurses, master's prepared Psychologists and master's prepared social workers.

- 7.5 **Stabilizing Treatment.** If an emergency medical condition is found to exist, the Hospital will provide necessary stabilizing treatment or an appropriate transfer.
- (a) "Stabilizing treatment" is considered as the treatment necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, with respect to a pregnant woman who is having contractions, the woman delivers the child and the placenta. If an individual at Hospital has an emergency medical condition that has not been stabilized, the Hospital will not transfer the individual unless it is an "appropriate transfer" (as defined below).
  - (b) To make an "appropriate transfer" to another medical care facility, the Hospital must (i) provide the stabilizing medical treatment within its capacity minimizing the risk to the individual or to the woman and unborn child; (ii) verify that the receiving facility has the space and qualified personnel available for the treatment of the individual; (iii) verify that the receiving hospital has agreed to accept the transfer of the individual and to provide the appropriate medical treatment; (iv) send pertinent medical records available at the time of the transfer to the receiving hospital (including available history, records related to the emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies, treatment provided, and the name/address of any on-call Physician who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment); and (v) effect the transfer through qualified persons and transportation equipment, including life support measures.
  - (c) An appropriate transfer, defined above, is only permitted where the patient (or the patient's authorized representative) requests the transfer, or a Physician has signed a certification that, based upon information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to the individual or, in the case of a woman in labor, to the woman or unborn child.
    - (i) A patient's (or authorized Representative's) request for transfer must be in writing and must indicate the reasons for the request and indicate that the patient is aware of the risks and benefits of transfer.
    - (ii) A written Physician certification must summarize the risks and benefits of the transfer.
    - (iii) If a Physician is not physically present in the Emergency Department at the time of transfer, a qualified medical person may sign the certification after consultation with a Physician who agrees with the certification. A qualified medical person is a P.A., APRN, emergency room Registered Professional Nurse, or labor and delivery Registered Professional Nurse. The consulting Physician must subsequently countersign the certification.
- 7.6 **Off-Campus Departments.** When a patient with an emergency medical condition presents to an off-campus Hospital department that does not include an Emergency Department, the patient will be provided screening and stabilization services at such off-campus department consistent with available resources and Hospital policy.
- 7.7 **Reporting.** The Hospital will report to the Centers for Medicare & Medicaid Services or the Oklahoma Department of Health and Senior Services any time the Hospital believes it has

received an individual who has been transferred from another hospital in violation of EMTALA. This report must be made within seventy-two (72) hours of the occurrence.

## **ARTICLE 8 AUTOPSIES**

- 8.1 **Securing Autopsies.** Every Member of the Medical Staff is expected to be actively interested in securing autopsies, and should attempt to secure an autopsy in all cases of unusual deaths and of medical-legal and educational interest. No autopsy shall be performed without written consent of a relative or legally authorized agent. All autopsies shall be performed by the Hospital pathologist or by a pathologist to whom the Physician may delegate the duty. The attending Physician shall be notified when an autopsy is being performed.