

Medical Staff Bylaws Of St. Elizabeth Healthcare

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Preamble

St. Elizabeth Healthcare is a health organization comprising four acute care hospitals, one critical access hospital and one drug and alcohol treatment center. Those facilities are St. Elizabeth Covington; St. Elizabeth Edgewood; St. Elizabeth Florence; St. Elizabeth Ft. Thomas; St. Elizabeth Grant; and St. Elizabeth Falmouth. The organization results from a merger of the St. Elizabeth Medical Center and the St. Luke Hospitals on October 28, 2008.

These Bylaws, together with the Rules and Regulations and policies to be created under them, govern the affairs of the new Medical Staff at each of the above facilities.

1. DEFINITIONS AND CONVENTIONS

1.1. Definitions

As used in these Bylaws, the following definitions apply:

- 1.1.1. **Affect Adversely** means reducing, restricting, suspending, revoking, denying or failing to renew Medical Staff membership or Clinical Privileges.
- 1.1.2. An **Allied Health Professional** or **AHP** is an individual whose qualifications, status, clinical duties and responsibilities are managed by the Medical Staff. "Privileged AHPs" are identified in Article 13 and hold Clinical Privileges. "Authorized AHPs" provide patient care, treatment or services but do not hold Clinical Privileges. Authorized AHPs presently serving at Hospital facilities are set forth in the Credentialing Manual. Neither Privileged AHPs nor Authorized AHPs are eligible for Medical Staff membership.
- 1.1.3. **Board** means the Board of Trustees of Saint Elizabeth Medical Center, Inc.
- 1.1.4. **Bylaws** means these Bylaws of the Medical Staff, as they may be amended from time to time.
- 1.1.5. **CEO** means the Chief Executive Officer of the Hospital.
- 1.1.6. **Clinical Privileges** or **Privileges** refers to the permission granted by the Board to those who admit patients and/or provide patient care, treatment or services by rendering specific professional, diagnostic, therapeutic, medical, dental or surgical services. Clinical Privileges includes, where appropriate, the authority granted to Authorized AHPs in accordance with Article 13 of these Bylaws.
- 1.1.7. **CMO** means the Chief Medical Officer of St. Elizabeth Healthcare or his or her designee.
- 1.1.8. **Complete Application** means an application for Medical Staff Membership or Clinical Privileges--

- 1.1.8.1. in which all forms have been fully filled in with responsive and accurate information;
 - 1.1.8.2. that is dated and signed in all required places;
 - 1.1.8.3. accompanied by all required documents;
 - 1.1.8.4. accompanied by all necessary complete and signed references; and
 - 1.1.8.5. supported by all additional documents and information requested by the CMO as a result of his or her review of the Application File.
- 1.1.9. **Criminal Conviction** means conviction of, or a plea of guilty or no contest to (a) any felony, or (b) any misdemeanor involving moral turpitude or related to the practice of a health-care profession, to Federal Health Program fraud or abuse, to third-party reimbursement, or to controlled substances.
- 1.1.10. A **Dentist** is an individual who holds a degree in dentistry and is currently licensed to practice dentistry in Kentucky.
- 1.1.11. **Fair Hearing Plan** means the procedures for hearings and appeals applicable to Practitioners set forth in these Bylaws, as they may be amended from time to time.
- 1.1.12. **Federal Health Program** means Medicare, Medicaid or any other federal or state program providing health-care benefits that is funded directly or indirectly by the United States government.
- 1.1.13. **Hospital** refers to each of the following facilities: St. Elizabeth Covington; St. Elizabeth Edgewood; St. Elizabeth Florence; St. Elizabeth Ft. Thomas; St. Elizabeth Grant; and St. Elizabeth Falmouth.
- 1.1.14. **Hospital Representatives** mean the Board, each Board member, each Board committee, the CEO, each Hospital employee, each Hospital committee, the Medical Staff, each Member, officer and committee thereof and each other individual who is authorized to gather, analyze, use or disseminate information, or assist in doing the same, concerning Practitioners and their qualifications to hold Medical Staff membership or Clinical Privileges.
- 1.1.15. **House Physicians** are Physicians (not part of the St. Elizabeth Family Medicine Residency Program) licensed in Kentucky who provide specific services defined in the House Physician privilege delineation they submit with their Medical Staff application, and whose relationship relating to House Physician services is further defined by contract with or employment by the Hospital. House Physicians who also hold other Privileges or are enrolled in a residency or fellowship program may also provide further care, treatment or services in accordance with those additional Privileges and/or the terms and supervision of the residency program.

- 1.1.16. An **Investigation** means the focused and purposeful gathering of information, records and other data respecting the competence, professional conduct or practice patterns of a Practitioner for the purpose of determining whether to take or recommend a Professional Review Action. Only the MEC or the Board may initiate an Investigation, in accordance with the provisions of Article 11. The routine functioning of the Medical Staff, of its committees, of the Hospital's performance improvement or resource management functions or committees and all discussions with a Practitioner relating to these matters do not constitute an Investigation.
- 1.1.17. **MEC** means Medical Executive Committee of the Medical Staff
- 1.1.18. **Medical Staff** means the single organized body of Physicians, Dentists and Surgical Podiatrists who have been admitted as Members and granted Clinical Privileges to attend to patients in the Hospital.
- 1.1.19. **Member** means a member of the Medical Staff.
- 1.1.20. **Notice** means written notification that is either (a) delivered in person, via messenger, commercial courier or otherwise or (b) faxed or mailed by certified mail return receipt requested, to the recipient's last known home or office address or (c) emailed, and the recipient acknowledges receipt by return email. Notice is complete upon delivery, faxing, mailing, or receipt of email acknowledgment.
- 1.1.21. **Peer Review Matter** is information, documents and other records obtained or created in the course of a Professional Review Activity and includes, but is not limited to:
- 1.1.21.1. information, data, reports or records supplied by any person at the Hospital or Medical Staff in furtherance of a Professional Review Activity;
 - 1.1.21.2. information, data, reports or records created by a Professional Review Body or by any of its members, employees, assistants or persons under contract in the course of a Professional Review Activity;
 - 1.1.21.3. conversations, discussions, deliberations, testimony or other oral communications relating to Professional Review Activities;
 - 1.1.21.4. reports that a Professional Review Body may make to the National Practitioner Data Bank.
- 1.1.22. A **Physician** is an individual who has received a doctor of medicine or doctor of osteopathy degree and is currently licensed to practice medicine in Kentucky.
- 1.1.23. **Practitioner** means a Physician, Dentist, Surgical Podiatrist or Allied Health Professional.
- 1.1.24. **President** means the President of the Medical Staff.

1.1.25. A **Professional Review Action** --

1.1.25.1. Has the following four characteristics:

1.1.25.1.1. It is an action or recommendation of a Professional Review Body

1.1.25.1.2. which is taken or made in the conduct of a Professional Review Activity and

1.1.25.1.3. which is based on the competence or professional conduct of an individual Practitioner that is harmful or potentially harmful to patients

1.1.25.1.4. where the action or recommendation affects or might Affect Adversely the Clinical Privileges of the Practitioner and/or, in the case of Physicians, Dentists and Surgical Podiatrists, membership on the Medical Staff.

1.1.25.2. A Professional Review Action includes:

1.1.25.2.1. for immunity purposes, all Professional Review Activities related to the Professional Review Action as well as all decisions not to take action; and

1.1.25.2.2. actions or recommendations pertaining to applicants who seek Medical Staff membership or Clinical Privileges.

1.1.25.3. A Professional Review Action does not include actions relating to a Practitioner's association with a professional society; to a Practitioner's fees, advertising or other acts to solicit business; to a Practitioner's participation in prepaid group health plans, salaried employment or any other manner of delivering health services; to a Practitioner's association with any particular class of health-care practitioner; or to any other matter that does not relate to the competence or professional conduct of the Practitioner.

1.1.26. A **Professional Review Activity** means any activity to determine whether a Practitioner may hold Clinical Privileges at the Hospital or, in the case of Physicians, Dentists and Surgical Podiatrists, membership on the Medical Staff, to determine the scope of such Privileges or membership or to modify such Privileges or membership.

1.1.27. A **Professional Review Body** means the Hospital, the Board, or any committee of the Hospital or Board that conducts Professional Review Activities. It includes each committee of the Medical Staff that assists the Hospital or the Board in Professional Review Activities.

1.1.28. **Reasonable Cause** for removal of a Medical Staff Officer, committee member or Department or section chairperson means:

1.1.28.1. Failure to satisfy the qualifications for Medical Staff membership;

- 1.1.28.2. Failure to discharge the responsibilities of Medical Staff membership;
- 1.1.28.3. Failure to discharge the responsibilities of the office for which he or she is elected; or
- 1.1.28.4. A final Professional Review Action that is reportable to the National Practitioner Data Bank has been taken against him or her.

1.1.29. **Rules and Regulations** refers to the Rules and Regulations of the Medical Staff and such other policies and manuals guiding the activities and structure of the Medical Staff as may be adopted and as the same may be amended from time to time pursuant to these Bylaws.

1.1.30. **Surgical Podiatrist** means podiatrists who held podiatric surgery Privileges at either St. Elizabeth Medical Center or the St. Luke Hospitals on the effective date of these Bylaws.

1.2. Conventions

1.2.1. When counting **Days**, the first day of any period is not counted; the last one is. If a period ends on a Saturday, Sunday or Federal holiday, then the period is deemed to end on the next business day. If a period is six days or shorter, do not count intervening Saturdays, Sundays or Federal holidays.

2. PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1. Purposes of the Medical Staff

The Medical Staff is organized and exists:

- 2.1.1. As a structure for the oversight of care, treatment and services by those who hold Clinical Privileges at the Hospital, for leadership in activities related to patient safety and for the education of patients and families;
- 2.1.2. As a framework for self-governance through the preparation of Bylaws, Rules and Regulations and policies that allow Members to act with a reasonable degree of freedom and confidence;
- 2.1.3. As a mechanism for evaluating applicants for Medical Staff membership and Clinical Privileges;
- 2.1.4. As a means for the Medical Staff to represent its Members and to communicate with the Hospital at all levels and to participate in all deliberations affecting the discharge of Medical Staff responsibilities;
- 2.1.5. As a resource to advance teaching, learning, education and advancement of clinical knowledge and skills;
- 2.1.6. As the sole body of Members accountable to the Board that makes recommendations to the Board with respect to the above, subject to approval by the Board as the ultimate authority.

2.2. Responsibilities of the Medical Staff

To carry out these purposes, the Medical Staff will:

- 2.2.1. Initiate, develop, and amend as necessary its own Bylaws and Rules and Regulations for review and approval by the Board;
- 2.2.2. Structure itself to establish and maintain a uniform standard of quality patient care, treatment and services;
- 2.2.3. Designate appropriate Members to provide oversight for such care, treatment and services;
- 2.2.4. Make recommendations to the Board respecting Medical Staff membership and Clinical Privileges;
- 2.2.5. Participate in performance improvement, utilization management and peer review and in programs to enhance patient safety and patient satisfaction;
- 2.2.6. Participate and cooperate with the Hospital in activities to achieve and maintain accreditations;
- 2.2.7. Participate with the Hospital in identifying and meeting community health needs.
- 2.2.8. Report to the Board and remain accountable for the foregoing.

2.3. Resolving Medical Staff-Board Conflicts

These Bylaws either permit or require the Medical Staff or MEC to make recommendations to the Board. The Board has the authority to accept, modify or reject such recommendations. Before taking any final action that would modify or reject a Medical Staff or MEC recommendation, the Board must convene the Executive Conflict Management Committee to discuss and attempt to resolve disagreement. Following reasonable attempts at resolution, and considering any recommendations the Committee may choose to make, the Board may take whatever action(s) it deems in its sole discretion are in the best interests of the Hospital.

3. MEDICAL STAFF MEMBERSHIP

3.1. Nature of Medical Staff Membership, Generally

Medical Staff membership is not a right but a privilege extended by the Board to those who continuously meet the qualifications and requirements set forth in these Bylaws. Unless acting under temporary or emergency Privileges as described in these Bylaws, no person (including those in administrative positions) may render health-care services independently at the Hospital without holding delineated Clinical Privileges. No person may admit patients to the Hospital unless he or she is a Member of the Medical Staff, and then only within the scope of his or her licensure and the Privileges he or she holds. A Member is not an employee or an independent contractor of the Hospital, unless such a relationship is established in writing between the Member and the Hospital.

3.2. Qualifications for Membership

Only Physicians, Dentists and Surgical Podiatrists who continuously meet the qualifications and requirements of Articles 3, 4 and 5 are eligible for Medical Staff membership. Each Member must:

- 3.2.1. Have graduated from a professional school and (except for House Physicians) completed in good standing an accredited post-graduate education program;
- 3.2.2. Hold a current license to practice medicine, dentistry or podiatry in Kentucky;
- 3.2.3. Not be under suspension under a Federal Health Program;
- 3.2.4. Possess good moral character and the ability to work cooperatively with others without disruption; and
- 3.2.5. To the extent he or she holds or seeks Clinical Privileges,
 - 3.2.5.1. Hold professional liability insurance coverage in an amount and with an insurer approved by the Board and confirm renewal of coverage on each policy anniversary date;
 - 3.2.5.2. Demonstrate current clinical competence, as specifically established by professional education, training and experience;
 - 3.2.5.3. Possess the physical, mental and emotional ability to exercise the Privileges he or she holds or requests;
 - 3.2.5.4. Have the ability to provide or arrange for continuous care to his or her patients; and
 - 3.2.5.5. For Members who first apply for membership after the date of approval of these bylaws, be and remain (with a lapse of no longer than one year) board certified in their principal practice specialty, or become and remain (with a lapse of no longer than one year) board certified within six years of completion of their post-graduate medical training. This rule is inapplicable to General Dentistry, which has no certifying board. Only those boards recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association or the American Board of Podiatric Surgery are acceptable.

3.3. Responsibilities of Medical Staff Membership

By applying for and holding Medical Staff membership, each Member agrees to:

- 3.3.1. provide continuous care to his or her patients at a generally recognized professional level of quality and efficiency, either personally or by means of coverage by an appropriately privileged Member;
- 3.3.2. abide by these Bylaws, the Rules and Regulations and all other rules, policies and regulations of the Medical Staff and of the Hospital;

- 3.3.3. abide by the Ethical and Religious Directives for Catholic Health Care Services while practicing at the Hospital and by other commonly accepted standards of professional ethics applicable to the Member's specialty;
- 3.3.4. participate in service call, in accordance with the Rules and Regulations;
- 3.3.5. participate in performance improvement, utilization management and peer review activities, activities to achieve and maintain accreditation and activities designed to measure and improve patient safety and patient satisfaction;
- 3.3.6. discharge in a responsible and cooperative manner such reasonable responsibilities and assignments as a Member may assume or receive by virtue of Medical Staff membership, including committee, department leadership and officer assignments;
- 3.3.7. work cooperatively with Members, non-Member health-care providers, Hospital administration and others;
- 3.3.8. provide accurate information in every application for Medical Staff membership or Clinical Privileges and promptly provide updated information as material changes occur. "Material" changes include all changes in contact and coverage information; health status; involuntary suspension, restriction or loss of membership or privileges at any health care entity; medical/dental license suspension, restriction or loss in any state; loss or restriction of DEA license; loss of required insurance; Federal Health Program exclusion; or Criminal Conviction;
- 3.3.9. complete medical records and other documents required by rule, regulation or policy in a timely manner;
- 3.3.10. make timely payment of dues and assessments as may be levied from time to time;
- 3.3.11. discharge such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff or MEC;

3.4. General Conditions of Medical Staff Membership

- 3.4.1. Term of Appointment: No appointment to the Medical Staff may exceed two years. Terms of appointment or reappointment begin on the date specified by the Board.
- 3.4.2. Effect of Other Affiliations: No person shall be entitled to membership in the Medical Staff merely because of his or her membership, status or Privileges at any other organization or facility.
- 3.4.3. Privileges Required: Membership by itself confers no Clinical Privileges. Members must separately apply for and hold Clinical Privileges in order to perform patient care services.
- 3.4.4. Medico-Administrative Officers: Physicians who hold administrative positions at the Hospital who wish to treat patients must apply for and

hold Medical Staff Membership and Clinical Privileges appropriate to the care to be provided.

- 3.4.5. History and Physical: A Physician or other Practitioner with appropriate Privileges must complete and document a physical examination and medical history for each patient not more than 30 days before or 24 hours after an admission to or registration at the Hospital, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that has been completed within 30 days before admission or registration, the physician primarily responsible for the care of the patient must complete and document, within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services an updated examination of the patient, including any changes in the patient's condition.
- 3.4.6. Leave of Absence: Subject to the provisions of the Rules and Regulations governing suspensions of impaired Practitioners, a Practitioner may obtain a voluntary leave of absence for a period not to exceed one year by submitting written notice containing the reason(s) for leave to the CEO and to the President. Unless excused by the President for health reasons or other extraordinary circumstances, the Practitioner must deliver the request at least 30 days in advance of the date leave is to begin. During such leave, the Practitioner's Privileges and prerogatives are placed in abeyance. At least 30 days prior to termination of the leave, the Practitioner may request reinstatement by written request to the MEC, which shall include a summary of his or her activities, maintenance of skills and continuing education during the leave. The MEC must then make a recommendation to the Board as to reinstatement. A voluntary resignation of membership and Privileges results:
 - 3.4.6.1. Where a Practitioner fails to bear the burden of establishing current licensure, insurance and competence;
 - 3.4.6.2. Where the period of requested leave was less than the unexpired period of appointment or Privileges and the Practitioner fails to request reinstatement within the time allowed; or
 - 3.4.6.3. Where the period of requested leave is equal to or greater than the unexpired period of appointment and/or Privileges grant and the Practitioner fails to apply in a timely manner for renewed membership or Privileges.

3.5. MEC Involvement in Board Decisions to Contract or Limit Services

- 3.5.1. The Board, subject to paragraph 3.5.2 and after consultation with the MEC not less than 30 days prior to taking action, may --
 - 3.5.1.1. establish exclusive contractual relationships with any individual or group of individuals for the provision of clinical services, or the management of specific clinical Departments (existing exclusive contractual relationships are not subject to this requirement);

3.5.1.2. close a Department or specialty or limit the number of Practitioners; or

3.5.1.3. add, define or limit the patient care services and types of health-care providers at the Hospital.

3.5.2. Such Board action of this type should take into consideration the efficient management of the Hospital; the availability, adequacy and extent of Hospital facilities, adequately trained support and monitoring personnel; standards of quality patient care; patient needs; community needs; and such other criteria as the Board, in consultation with the MEC, may develop.

3.5.3. Exclusive Contracts: Exclusive contracts shall only be authorized by specific action of the Board. The duration, terms and extent of these contracts shall be governed by Board policy.

3.5.3.1. A Member under an exclusive contract (or who is affiliated with a group under an exclusive contract) with the Hospital must meet and hold continuously all the necessary qualifications of Medical Staff membership and Clinical Privileges applicable to the facilities he or she uses or the services he or she provides.

3.5.3.2. Termination of an exclusive contract between the Hospital:

3.5.3.2.1. and a Member (for reasons other than competence or professional conduct) is deemed a voluntary resignation of the Member's Medical Staff Membership and clinical privileges;

3.5.3.2.2. and a group is deemed a voluntary resignation of the Membership and privileges of each Member in the group.

3.5.3.3. Termination of any relationship between a group holding an exclusive contract and one or more of its members is deemed a voluntary resignation of the Membership and privileges of the departing Member(s).

3.5.3.4. Notwithstanding Section 3.5.3.2.1 above, termination of an exclusive contract does not result in the resignation of Membership or Privileges of a Practitioner to the extent he or she holds other Privileges that are not the subject of an exclusive contract at the Hospital.

3.5.3.5. When the Hospital enters into an exclusive contract, Members must honor the exclusivity policy and, except in emergencies, arrange for the care of their patients in accordance with the Hospital policy and the terms of the applicable agreements.

3.5.3.6. Applications for Clinical Privileges covered by a Hospital exclusivity policy will not be accepted or processed, except in

accordance with the Board policy and/or any existing written agreements.

3.6. Voluntary Resignations from the Medical Staff

A Medical Staff Member may voluntarily resign membership and/or Privileges. Such resignation will be effective upon delivery of written notice to the medical staff office, the President, or the CEO, and it shall be effective immediately unless otherwise stated in the written notice and agreed to by the CEO and President.

4. CATEGORIES OF MEMBERSHIP

There are three categories of Medical Staff membership. They are Active, Courtesy, and Honorary. The qualifications and responsibilities listed below are in addition to the general qualifications and responsibilities listed in the preceding Article.

4.1. Active

- 4.1.1. Qualifications: Members with 20 or more patient encounters or referrals to a hospitalist in a given year qualify for Active Membership.
- 4.1.2. Rights: Active Members may admit patients without limitation within the scope of granted privileges (except as may be otherwise provided in the Medical Staff Rules and Regulations or prohibited by law); attend and vote at all department, section and committee meetings of which they are members and at all Medical Staff meetings; hold office; and chair committees. Active Members who are at least 65 years old or have been on Active status for at least 25 years attain Senior Active status and may be excused upon request from service call requirements.
- 4.1.3. Responsibilities:
 - 4.1.3.1. Contribute to the organization and administration of the Medical Staff through meeting and committee participation, attendance and voting; and
 - 4.1.3.2. Take service call unless excused, pursuant to the Rules and Regulations.
- 4.1.4. Transition to and from Active Category: The MEC may move a Member to or from the Active Category upon a demonstration that the Member meets, or does not meet, the qualifications for the Category. The Member may request a review of such a decision by the MEC, but following such further review, the MEC's decision is final.

4.2. Courtesy

- 4.2.1. Qualifications: Courtesy staff consists of:
 - 4.2.1.1. Members with fewer than 20 patient encounters or referrals to a hospitalist in a given year who do not qualify for Active staff;

4.2.1.2. Initial applicants, who serve their first year as Courtesy Members. The MEC may extend this initial one-year period for an additional period of a year or less; and

4.2.1.3. House Physicians holding no other Privileges. A House Physician holding no other Privileges is eligible for transition to the Active Category if and when he or she satisfies each of the following criteria:

4.2.1.3.1. Completion of their residency training program;

4.2.1.3.2. Service of at least one year as a Courtesy Member;
and

4.2.1.3.3. Has 20 or more patient encounters or referrals to a hospitalist in the year prior to transition.

4.2.2. Rights: Courtesy Members may admit patients without limitation within the scope of granted privileges (except as may be otherwise provided in the Medical Staff Rules and Regulations or prohibited by law); attend Medical Staff, department and section meetings and serve on committees but may not chair any committees or meetings, hold office or vote.

4.2.3. Responsibilities: Courtesy Members may request or be required to take service call in accordance with the provisions of the Rules and Regulations.

4.3. Honorary

4.3.1. Qualifications: Honorary Members are nominated by the MEC and approved by the Board for distinguished service. They must have served as an Active Member.

4.3.2. Rights: Honorary Members may, at their discretion, attend Medical Staff, committee and educational meetings but may not hold office or vote. They may not admit patients or exercise Clinical Privileges.

5. APPOINTMENT/REAPPOINTMENT

5.1. Nature of Appointment; Processing

The Board makes appointments and reappointments to the Medical Staff and delineates Clinical Privileges to individual members based upon the recommendations of the Medical Staff. Applications are processed in accordance with the Credentialing Manual, based upon the professional criteria set forth in this Article. The MEC may amend the Credentialing Manual without submission of changes to a vote of the full Medical Staff, and changes are effective when approved by the Board. Neither the MEC nor the Board may change the Credentialing Manual unilaterally.

5.2. General Description of the Application Process

In overview, the Medical Staff Office conducts primary source verifications of pertinent information once it receives a Complete Application. When that office completes verification, the CMO reviews and forwards the application to each Department or section in which the applicant seeks Clinical Privileges. The appropriate Department or section chairperson(s) then forwards the application file, with recommendations, to the Credentials Committee for review. The Credentials Committee, in turn, forwards the file and its recommendation to the MEC for final recommendation. The MEC forwards a recommendation, if favorable, to the Board or Board subcommittee for further handling and, if appropriate, final approval. Unfavorable recommendations that are based upon competence or professional conduct are processed in accordance with the Fair Hearing Plan.

5.3. Effect of Filing an Application

Each person who signs and files an application for Medical Staff membership or Clinical Privileges --

- 5.3.1. Warrants that the information submitted with the application and on all prior applications, as amended, is complete and accurate; agrees to provide updated information as soon as practicable concerning each change to a response to any question on an application; and agrees that material misstatements, omissions or misleading statements may be grounds for suspension or termination without a hearing under the Fair Hearing Plan;
- 5.3.2. Consents to appear for such interviews and provide such additional information or documents as any Professional Review Body may require;
- 5.3.3. Authorizes each Professional Review Body to consult with persons who may have information bearing on the applicant's qualifications;
- 5.3.4. Consents to the inspection of all documents and the release of all information that any Professional Review Body may determine to be relevant in assessing the applicant's qualifications, including all records and documents pertaining to his or her licensure, specific training, experience, current competence and ability to perform the privileges requested;
- 5.3.5. Agrees to submit any reasonable evidence of current ability to perform the privileges requested and to submit to such physical or mental examination as the MEC may require. Taking or passing a physical or mental examination must not be a part of the application process, but the exercise of Clinical Privileges that are otherwise granted may be made subject to the successful completion of such an examination. The identity of the examining physician(s) must be by mutual consent. In the event of a disagreement concerning the need for an examination or the identity of the examining physician(s), the matter must be referred to the Executive Conflict Management Committee, whose decision on the matter is final.
- 5.3.6. Releases all Hospital Representatives, each Professional Review Body and its individual members and all persons who assist the body from liability for acts performed in connection with the evaluation of the applicant's qualifications;

- 5.3.7. Releases all persons from liability who provide information, including information that is otherwise privileged or confidential, in connection with the evaluation of the applicant's qualifications;
- 5.3.8. Authorizes Hospital Representatives to release information pertaining to the applicant's qualifications to other hospitals, health-care entities and authorized health-care licensing, data collection and reporting agencies, to the extent to which consented in writing or permitted or required by law, and releases the Hospital Representatives for so doing;
- 5.3.9. Acknowledges receipt of or access to a copy of the Bylaws, Rules and Regulations and all policies of the Medical Staff and of the Hospital relating to appointment to the Medical Staff and the delineation of Clinical Privileges, and agrees to be bound by them (and all revisions to those documents);
- 5.3.10. Agrees to perform and abide by the obligations set forth under Responsibilities of Medical Staff Membership in the Bylaws, including the obligation to provide continuous care for his or her patients;
- 5.3.11. Agrees to comply with all state and federal laws regarding the practice of medicine, including without limitation, the prohibitions against fee-splitting, antireferral and antikickback statutes;
- 5.3.12. Agrees to exhaust as the exclusive remedy all applicable steps provided in these Bylaws in the event any Professional Review Body takes, recommends or considers the taking or recommending of a Professional Review Action. Such steps include, without limitation, the provisions of the "Resolving Professional Competence, Conduct or Discipline Issues" Article and the Fair Hearing Plan.

5.4. Professional Criteria for Evaluating Applications

- 5.4.1. No Discrimination: Neither Medical Staff membership nor the grant, modification or renewal of Clinical Privileges may be denied to any person on the basis of age, sex, race, religion, creed, national origin, disability or any other consideration not impacting on the applicant's ability to competently exercise the Privileges for which he or she has applied. Standards for credentialing and privileging will be uniformly applied to all applicants.
- 5.4.2. Incomplete Information: It is the applicant's responsibility to provide all information and documents that these Bylaws, the Credentialing Manual and any reviewing official or body of the Medical Staff or Hospital requests in order to fully evaluate an applicant's qualifications. Failure to comply results in an incomplete application. Incomplete applications may be returned and will not be further processed until the applicant supplies all necessary information. Applications for reappointment that remain incomplete may be treated as a voluntary resignation of Medical Staff membership and Clinical Privileges with no rights to hearing or appeal.

- 5.4.3. Material misstatements: Material misstatements, omissions or misleading statements are grounds for denial of an application or reapplication, without a hearing under the Fair Hearing Plan.
- 5.4.4. Initial Applicants: Review of an initial applicant measures whether he or she meets the prescribed qualifications for Medical Staff membership, including current licensure, relevant training or experience, current competence and the ability to perform the Clinical Privileges he or she has requested.
- 5.4.5. Applicants for Reappointment and for Changes of Privileges: Each such applicant must meet the criteria for initial applicants. In addition, he or she must satisfy the following additional criteria:
 - 5.4.5.1. Satisfactory evidence of current professional competence, judgment and clinical and technical skills;
 - 5.4.5.2. Compliance with each of the Responsibilities of Medical Staff Membership set forth in Article 3 of these Bylaws; and
 - 5.4.5.3. Cooperation with others and avoidance of disruptive or other unprofessional behavior that impedes the Hospital's delivery of quality care.

5.5. Time Periods for Processing Applications

The application process must be completed within six months of receipt of a Complete Application. Applications that the Board does not act upon within that six-month period are deemed stale, and the applicant must submit a new application. The MEC may extend this six-month period for good cause and may attach conditions.

6. CLINICAL PRIVILEGES

6.1. Delineation of Clinical Privileges

- 6.1.1. Generally: Medical Staff membership by itself confers no Clinical Privileges. Each Practitioner must request Clinical Privileges and may only practice within the scope of the Privileges the Board grants.
- 6.1.2. Department Responsibility for Delineations: Each Department must have or develop Privileges pertinent to its Department in accordance with the Credentialing Manual.
- 6.1.3. Requests For Privileges: Each Practitioner who desires specific Clinical Privileges, temporary Privileges or a modification of existing Privileges must make a written request for them. The burden is on the applicant to supply all the necessary information for evaluation.
- 6.1.4. Basis for the Granting of Privileges: Privileges are awarded on the basis of the applicant's current licensure, education, training, experience, competence and ability. Clinical privileges to new applicants or applicants for new Privileges are subject to a period of post-award focused

professional practice evaluation to assure an acceptable level of competence. Clinical Privileges requests on reappointment require proof of satisfactory professional performance, judgment and clinical and technical skills as established through ongoing professional practice evaluation. The Board may limit the exercise of certain Privileges to specific Hospital facilities that have the necessary equipment, space and skilled personnel to support them. Otherwise a Practitioner may exercise a grant of Privileges at any or all Hospital facilities.

- 6.1.5. Procedures: Privilege requests will be processed in the same manner as requests for Medical Staff membership in accordance with the Credentialing Manual.
- 6.1.6. Duration of Privileges: Privileges are awarded for a period not exceeding two years, or for such shorter period as may be specified.

6.2. Temporary Privileges

- 6.2.1. Circumstances: Temporary privileges are available to Practitioners or AHPs under two circumstances:
 - 6.2.1.1. Initial applicants awaiting MEC/Board action who meet the further qualifications set forth in the Credentialing Manual; or
 - 6.2.1.2. To fill an important patient care, treatment or service need, on a case-by-case basis and for a limited period of time, subject to the further qualifications set forth in the Credentialing Manual.
- 6.2.2. Time Limits: Grants of temporary privileges may not exceed 120 days.
- 6.2.3. Processing of Temporary Privilege Applications: Requests for temporary privileges are submitted and processed in accordance with procedures in the Credentialing Manual.
- 6.2.4. Standards for Approval: The CEO and President (or their designees) may grant a request for temporary privileges --
 - 6.2.4.1. to an initial applicant if the applicant meets the qualifications set forth in these Bylaws and in the Credentialing Manual, all primary sources have been verified, the review process for applications raises no concerns about the applicant and the application is ready for presentation to the MEC; or
 - 6.2.4.2. to fulfill an important patient care need, rarely, for a specific patient and on a case-by-case basis, for a period of 72 hours or the duration of the patient's hospital stay, whichever is longer. Such privileges may be granted in accordance with the Credentialing Manual upon a demonstration of Kentucky licensure (or in the case of a Physician, for consultation only within the meaning of KRS § 311.560(2)(b)(1), licensure in the applicant's actual state of residence) and current competence.

- 6.2.5. Procedure After Award: A grant of temporary privileges does not ensure an award of Medical Staff Membership or regular Clinical Privileges. The responsible Department or section chairperson may impose consultation or reporting requirements as part of his or her customary monitoring activities.
- 6.2.6. Denial or Termination: The CEO or designee may, upon consultation with the President or designee, deny, modify or terminate temporary privileges. Such actions, unless otherwise described, are deemed not to relate to the applicant's or holder's professional competence or conduct and do not entitle him or her to a hearing under the Fair Hearing Plan. Grounds not entitling a Practitioner to a hearing may include, but are not limited to, the following:
- 6.2.6.1. the applicant's failure to bear the burden of providing sufficient information regarding his or her licensure, insurance or competence;
 - 6.2.6.2. the information reasonably available is insufficient under the circumstances to allow or continue to allow the practitioner to exercise the requested privileges.
 - 6.2.6.3. in cases of specific patient care need, the need has diminished or abated.
- 6.2.7. Hearing Right: Denials or terminations that expressly relate to an applicant's competence or professional conduct, when approved by the MEC, entitle the applicant to hearing rights under the Fair Hearing Plan.

6.3. Emergency Privileges

Where an emergency exists (meaning that immediate treatment is necessary to prevent serious or permanent harm, to preserve life or to prevent the serious deterioration or aggravation of a condition), any Member is authorized to do everything possible, within the authority of his or her license, to address the emergency. He or she may do so irrespective of his or her Medical Staff status, Department assignment or Clinical Privileges. He or she must summon help as soon as possible to arrange for follow-up care by an appropriately privileged Member.

6.4. Disaster Privileges

In the event that the Hospital has activated its Emergency Operations Plan and is unable to meet immediate patient care needs through appropriately privileged Members of the Medical Staff, the Hospital CEO or Medical Staff President or their designees may issue Disaster Privileges. The option to grant Disaster Privileges rests in the sole discretion of the grantor on a case-by-case basis in accordance with the needs of the Hospital and its patients and the qualifications of the available volunteers. The mechanisms for the award of Disaster Privileges, the means of identifying privilege holders, oversight of privilege holders and decisions to continue or terminate Disaster Privileges are set forth in the Credentialing Manual.

6.5. Telemedicine Privileges

The Board may create and grant Clinical Privileges that a Practitioner at a distant site exercises via a telemedicine link. The processes for awarding telemedicine Privileges are set forth in the Credentialing Manual.

7. CLINICAL DEPARTMENTS

7.1. Organization of Departments

- 7.1.1. The Medical Staff is organized into clinical Departments. The Departments of the Medical Staff are Medicine and Surgery.
- 7.1.2. Departments may enact reasonable rules to govern their affairs. Rules are effective when approved by the MEC. They may meet as often as necessary to carry out their purposes. The Medical Staff President is an ex officio member of each Department, without vote.

7.2. Organization of Sections

- 7.2.1. The MEC may establish, modify or eliminate such sections within the Departments as it deems appropriate.
- 7.2.2. Interim Provision: Subject to the authority granted in the immediately preceding paragraph, the Medical Staff establishes the following initial sections:
 - 7.2.2.1. Department of Medicine: Sections of Emergency Medicine, Medical Subspecialties, Pediatrics, Primary Care Medicine and Psychiatry.
 - 7.2.2.2. Department of Surgery: Sections of Anesthesiology, Obstetrics/Gynecology, Pathology, Radiology and Surgical Subspecialties.
- 7.2.3. Sections are primarily responsible for the safe, efficient and effective delivery of care in their respective practice specialties. Subject to MEC approval, they may organize themselves, conduct their affairs and appoint such additional section leaders as may advance these responsibilities. In the event of conflict among sections, the affected sections' first resort is to attempt resolution in good faith among themselves.
- 7.2.4. Sections may enact reasonable rules to govern their affairs. Rules are effective when approved by the MEC. They meet as often as necessary to carry out their purposes. The Department chairperson and the Medical Staff President is an ex officio member of each section, without vote.

7.3. Assignments to Departments and Sections

Based upon the request of a practitioner and the recommendation of Department and section chairs, the MEC shall assign each Practitioner to one Department and one section. Each Practitioner must possess Clinical Privileges that are related to the care provided by the Department and section. Practitioners may hold Privileges in more than one Department and section but may only vote in their assigned Department and section and are subject to the rules

and regulations of the Department and section to which they are assigned and of those Departments and sections in which they hold Privileges.

7.4. Department and Section Leadership

- 7.4.1. Positions: Each Department and section has a chairperson and such other leaders as they may designate from time to time.
- 7.4.2. Qualifications: Department and section chairpersons must be Active Members and either board certified in their specialty or able to establish affirmatively their comparable competence.
- 7.4.3. Selection: Subject to the interim provisions immediately below, Department chairpersons are selected by majority vote of the Department's Active Members. Section chairpersons are selected by majority vote of the section, unless otherwise established by contract. Departments and sections may use mail balloting instead of voting at a meeting. The winner is the candidate with the most votes cast at a meeting or the most mail ballots submitted.
- 7.4.3.1. Interim provisions-Medicine and Surgery: Upon approval of these bylaws, the chairpersons of Medicine and Surgery at St. Elizabeth and St. Luke, duly elected under their previously applicable medical staff bylaws, become department co-chairpersons of their respective departments. Each such co-chair retains primary responsibility at the facilities whose staffs elected them. Upon the expiration of a co-chair's term as defined by the previous bylaws, the other chairperson becomes sole department chair. Upon the expiration of the second co-chair's term, the department must elect a successor chairperson of the department.
- 7.4.3.2. Interim provisions-Other department leaders become section leaders: Upon approval of these bylaws, the chairpersons of Anesthesiology, Emergency Medicine, Obstetrics/Gynecology, Pathology, Pediatrics, Psychiatry and Radiology, duly elected under their previously applicable bylaws, become section co-chairpersons. Each such co-chair retains primary responsibility at the facilities whose staffs elected them. Upon the expiration of a co-chair's term as defined by the previous bylaws, the other chairperson becomes sole section chair. Upon the expiration of the second co-chair's term, the section must elect a successor chairperson of the section.
- 7.4.3.3. Interim provisions-St. Elizabeth Sections of Family Medicine and Internal Medicine: Upon approval of these bylaws, the Co-Presidents of the Medical Staff will appoint a St. Luke successor chair of the Family Medicine section. The Family Medicine and Internal Medicine chairpersons of these sections become co-chairpersons of the new section of Primary Care Medicine. Upon the expiration of a co-chair's term as defined by the previous bylaws, the other chairperson becomes sole section chair. Upon the expiration of the second co-chair's term, the section must elect a successor chairperson of the section.

7.4.3.4. Interim provisions-St. Elizabeth Section of Cardiovascular Medicine: Upon approval of these bylaws, the co-Presidents shall appoint an interim chair of the section of Surgical Subspecialties. The interim chair shall serve out the unexpired term of the existing St. Elizabeth section chair of Cardiovascular Medicine.

7.4.3.5. Interim provisions-Election of a Medical Subspecialties Section chair: Upon approval of these bylaws, the members of the Medical Subspecialties section must promptly meet and elect a section chairperson.

7.4.4. Tenure: Department and section chairpersons serve for a period of two years, unless they sooner resign or are removed, and they may succeed themselves if duly re-elected.

7.4.5. Resignations, Vacancies and Removal

7.4.5.1. Any Department or section chairperson may resign by giving written notice to the MEC.

7.4.5.2. In case a Department or section vacancy, or if a chairperson resigns, is unable to serve or is removed, the MEC should fill his or her vacancy promptly with a qualifying Member on an interim basis until a new chairperson is selected and approved.

7.4.5.3. A Department or section chairperson may be removed for Reasonable Cause by the MEC or by a majority of Active Members in the Department or section who attend and vote at a meeting called for that purpose, or if the Member no longer meets the qualifications to be chairperson.

7.5. Department Responsibilities

7.5.1. Department chairpersons: Department chairpersons have ultimate responsibility within their Departments for the activities listed below. Sections have primary responsibility for each activity within their sections. The sections will discharge responsibilities of the Medical Staff pertaining to their specialty that are not specifically enumerated below.

7.5.1.1. All clinically related activities of the Department, including but not limited to service obligations, medical records compliance and disruptive conduct;

7.5.1.2. All administratively related activities of the Department, unless otherwise provided for by the Hospital;

7.5.1.3. Continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges;

7.5.1.4. Recommending to the MEC the criteria for Clinical Privileges that are relevant to the care provided in the Department;

- 7.5.1.5. Recommending Clinical Privileges for each Practitioner assigned to the Department;
- 7.5.1.6. Assessing and recommending to the MEC off-site sources for needed patient care services not provided by the Department or the Hospital;
- 7.5.1.7. The integration of the Department into the other functions of the Hospital;
- 7.5.1.8. The coordination and integration of interdepartmental and intradepartmental services within the Hospital;
- 7.5.1.9. The development and implementation of policies and procedures that guide and support the provision of care, treatment or services within the Department;
- 7.5.1.10. The recommendations for a sufficient number of qualified and competent persons to provide care or service;
- 7.5.1.11. The determination of the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care, treatment or services;
- 7.5.1.12. The continuous assessment and improvement of the quality of care, treatment and services;
- 7.5.1.13. The maintenance of performance improvement programs, as appropriate;
- 7.5.1.14. The orientation and continuing education of all persons in the Department;
- 7.5.1.15. Recommendations for space and other resources needed by the Department;
- 7.5.1.16. Determining the type of data to be collected for ongoing professional practice evaluations and forwarding recommendations to the MEC for approval;
- 7.5.1.17. Enforcing the Medical Staff Bylaws, Rules and Regulations and governing body bylaws, rules and policies within the Department;
- 7.5.1.18. Implementing actions of the MEC or the Board that affect the Department; and
- 7.5.1.19. Performing such other responsibilities as the MEC or Board may reasonably require.

8. OFFICERS

8.1. Qualifications, Tenure, Selection and Removal

- 8.1.1. Identity: The officers of the Medical Staff are the President, President-Elect and the Immediate Past President. Interim provision: In the years 2009 and 2010, there will be two Presidents and two Immediate Past Presidents, each holding their positions pursuant to election under relevant provisions of the previous bylaws of St. Elizabeth Medical Center and St. Luke Hospitals.
- 8.1.2. Qualifications: Medical Staff officers must be and remain Active category Members in good standing at the time of nomination and election and throughout their tenure.
- 8.1.3. Tenure: Subject to section 8.1.1, the President, President-Elect and Immediate Past President each serve two-year terms. Officers commence their terms on January 1 following their election and serve until removal, resignation or natural expiration of their term.
- 8.1.4. Selection: Officers are selected as follows:
- 8.1.4.1. The President-Elect succeeds to President at the end of his or her term; the President, in turn, succeeds to Immediate Past President.
- 8.1.4.2. A President-Elect is selected every two years.
- 8.1.4.3. In September of each even numbered year, the President appoints a nominating committee comprising at least three Active Members. The nominating committee must propose two or three qualified candidates for President-Elect. Members may propose candidates to the nominating committee for the committee's consideration for addition to the slate. The nominating committee must present their final slate of candidates to the President not later than October 30.
- 8.1.4.4. Elections are conducted by mail ballot in November. After the expiration of a 14-day voting period, the candidate with the most votes wins.
- 8.1.4.5. Transition provision: For the office of President-Elect in 2009-10 (which would have otherwise been filled by an election in 2008), the Medical Staff will hold a special election within 90 days of the final approval of these Bylaws. It shall conduct the election using the process described above. The President-Elect then serves until assuming the office of President on January 1, 2011.
- 8.1.5. Removal from Office: The Medical Staff may remove an officer for Reasonable Cause at a meeting held solely for that purpose and in accordance with this section. Any Active Member may initiate a removal vote by delivering a written removal petition to the MEC signed by one-quarter of all Active Members eligible to vote and stating the specific

grounds on which petitioners seek removal. Upon the MEC's certification that the petition contains sufficient valid signatures, it must retain an independent person to oversee the removal vote process. The overseer's responsibility is to ensure the conduct of a fair vote. His powers include, but are not limited to, in the overseer's discretion, setting the manner of publication of the removal vote, scheduling of the removal vote meeting, conducting the meeting and counting the votes. Removal vote shall be by secret written ballot, on a form distributed at the meeting and submitted at the meeting by Active Members eligible to vote. Proxy voting or submission of ballots on behalf of absent Members is not permitted. Ballots for removal cast by at least two-thirds of all valid ballots submitted at the meeting effects removal. In his or her discretion, the overseer may defer announcement of the result to another time to allow for counting and verification of votes cast. The overseer must promptly count the votes and certify the results to the MEC. The overseer's certified results are final. The medical staff office must store the votes in a sealed envelope for 90 days, after which they must be destroyed.

- 8.1.6. Vacancies: If the office of the President becomes vacant, the President-Elect serves his or her unexpired term, followed by the term to which the President-Elect was elected. In such an event, an election, conducted when and as described above, must be held to fill a vacancy in the office of President-Elect, and the person so elected shall assume the President's office upon the expiration of his or her predecessor's term. The MEC may appoint an interim President-Elect to fill a vacancy in that office until an election can be held. A vacancy in the office of Immediate Past President is not filled.

8.2. Duties of Officers

Medical Staff officers are responsible for discharging the duties listed below.

- 8.2.1. President (During 2009 and 2010, the two presidents will share and coordinate discharge of these responsibilities)
 - 8.2.1.1. Coordinate the activities of the Medical Staff with the rest of the Hospital;
 - 8.2.1.2. Communicate with the Board and CEO and represent the opinions, policies, concerns, needs and grievances of the Medical Staff;
 - 8.2.1.3. Speak for the Medical Staff on external professional and public relations matters;
 - 8.2.1.4. Report to the Board on the quality of care, treatment and services;
 - 8.2.1.5. Communicate the policies of the Hospital and the Board to the Medical Staff;

- 8.2.1.6. Assure Medical Staff compliance, cooperation and participation in performance improvement, utilization management and accreditation compliance programs;
- 8.2.1.7. Enforce the Medical Staff Bylaws, Rules and Regulations, policies and procedures and ensure compliance with and adherence to procedural safeguards under the Fair Hearing Plan, where it is applicable;
- 8.2.1.8. Call, set the agenda for and preside at meetings of the Medical Staff;
- 8.2.1.9. Appoint members to all standing, special and multidisciplinary Medical Staff committees except the MEC;
- 8.2.1.10. Serve as chairperson of the MEC and as an ex officio member without vote (except in cases of a tie) on all other Medical Staff committees. (He or she may vote without restriction in committees of which he or she is a member.); and
- 8.2.1.11. Perform such other tasks as the MEC or the Board may reasonably request.

8.2.2. President-Elect

- 8.2.2.1. Serve as a member of the MEC;
- 8.2.2.2. Assume the duties of the President in his or her temporary or permanent absence or disability;
- 8.2.2.3. Assure that proper notice of all Medical Staff meetings is served and that attendance is taken;
- 8.2.2.4. Assure that accurate and complete minutes of all Medical Staff meetings are taken;
- 8.2.2.5. Assure the maintenance of all records and correspondence;
- 8.2.2.6. Assure the report of official actions of the MEC to appropriate committees, Departments, sections and individuals;
- 8.2.2.7. Supervise the collection and accounting of Medical Staff funds;
- 8.2.2.8. Assume such other duties pertaining to his or her office as the President may reasonably request.

8.2.3. Immediate Past President: Serve as member of the MEC.

9. COMMITTEES

9.1. Committees, Generally

The standing committees of the Medical Staff are the MEC, the Credentials Committee, the Cancer Committee and the Bylaws Committee. The composition, responsibilities and functions of all committees other than the MEC are set forth in the Medical Staff Committee Manual. The MEC may establish committees (either standing committees or ad hoc committees) and amend the Committee Manual as necessary to carry out Medical Staff responsibilities. Amendments to the Committee Manual are not effective until approved by the Board. To the extent that any committee performs as a Professional Review Body, the proceedings and records of that committee shall be confidential and shall be regarded as Peer Review Matter within the meaning of these Bylaws. All tangible Peer Review Matter must be securely stored in the Medical Staff Office.

9.2. Medical Executive Committee

9.2.1. Composition Generally: No Medical Staff Member is ineligible for membership on the MEC solely because of his or her professional discipline or specialty, but a majority of the voting MEC must be fully licensed M.D.s or D.O.s actively practicing at the Hospital. The CEO or his or her designee is an ex officio member without vote. The Medical Staff President is chairperson of the committee. The President votes only in case of a tie. The MEC may invite others to participate in all or parts of any meeting, but it may excuse all such others and meet in executive session as necessary and in its sole discretion.

9.2.2. Specific Composition: To transition from two medical staffs to one, the following composition rules apply:

9.2.2.1. Initial Composition: Upon approval of these Bylaws, the MEC consists of the combined members of the Medical Executive Committees of the St. Elizabeth Medical Center and of the St. Luke Hospitals, as those committees were constituted on the date of approval of these Bylaws.

9.2.2.2. Transition Composition: As the terms of each MEC member expires in accordance with their previously applicable medical staff bylaws or upon their request for resignation and early transition to a single chairperson, his or her MEC membership ceases.

9.2.2.2.1. In the case of Department and section chairpersons sharing common clinical responsibilities (i.e., the previously existing Departments/sections of Anesthesiology, Emergency Medicine, Medicine, Obstetrics/Gynecology, Pathology, Radiology, Surgery, Pediatrics and Psychiatry), the Department or section chairperson duly elected under these Bylaws replaces the latter of the two paired leaders to leave.

9.2.2.2.2. The St. Elizabeth section chairpersons of Family Medicine and Internal Medicine become interim co-chairs of the new section of Primary Care Medicine.

9.2.2.2.3. The co-Presidents shall appoint an interim section chairperson of the new section of Surgical Subspecialties to

serve out the remaining term of the St. Elizabeth section chair of Cardiovascular Medicine.

9.2.2.2.4. MEC membership of the new section chairperson of Medical Subspecialties will commence upon his or her election by the section.

9.2.2.2.5. In the case of officers, the medical staff presidents whose terms expired at the end of 2008 become co-holders of the position of Immediate Past President under these Bylaws; and the presidents elect become co-Presidents. The co-Presidents, in 2011, become co-holders of the position of Immediate Past President through the end of 2012.

9.2.2.2.6. The Chairpersons of the Credentials, Bylaws and Patient Care Committees become non-voting members of the MEC upon approval of these Bylaws and serve until the single successor for each committee is duly appointed.

9.2.2.2.7. At-large members of the prior MECs are not replaced and cease to be members of the MEC as of the date of approval of these Bylaws.

9.2.2.3. Final Composition: The voting members of the MEC are the Medical Staff President, the President-Elect, the Immediate Past President, the Department chairpersons and the chairperson of each section as the Department chairpersons may establish and the sections may elect.

9.2.3. Meetings: The MEC must meet at least 10 times a year and keep detailed minutes of each meeting.

9.2.4. Responsibilities: MEC responsibilities include:

9.2.4.1. Adopting and amending Rules and Regulations and policies, including the Credentialing Manual and Committee Manual;

9.2.4.2. Representing and acting for the Medical Staff between Medical Staff meetings;

9.2.4.3. Reviewing, acting and reporting Medical Staff recommendations directly to the Board on matters pertaining to Medical Staff structure; mechanisms to review credentials and delineate Clinical Privileges; recommendations of individuals for Medical Staff membership and delineated Clinical Privileges; participation of the Medical Staff in performance improvement activities; and the mechanisms for Medical Staff Membership, discipline, terminations and fair hearing procedures; and

9.2.4.4. Receiving and acting on reports and recommendations from Medical Staff committees, clinical Departments and assigned activity groups.

9.2.4.5. Managing conflict between the MEC and the Medical Staff. Any Member or AHP may address the MEC, in person or in writing, on any grievance or other matter pertaining to Medical Staff governance, membership, Clinical Privileges or patient safety. Members must first attempt resolution in their section and Department of all concerns relating to matters in Bylaws Article 7.5. Consideration by the MEC is subject to reasonable constraints of time and agenda. The MEC may adjourn to collect additional information before taking further action. Resolution by the MEC is final. If a decision is appropriate, the MEC should inform the petitioner of its determination, subject to confidentiality constraints. Nothing in this subsection precludes a Member or AHP from communicating directly with the Board subject to Board limitations.

9.2.5. An MEC member may be removed for Reasonable Cause by the MEC or by a two-thirds vote of Active Medical Staff Members.

9.3. Characteristics Common to All Other Committees

Standing committees (other than the MEC) and such other committees as may be created by the MEC from time to time have the following characteristics, unless these Bylaws or the Committee Manual provides otherwise:

9.3.1. Composition: All committees must be composed of at least two Active Members. The President appoints committee chairpersons and members, subject to approval by the MEC. Non-Medical Staff committee members may serve without vote. The President and the CEO (or their designees) are ex officio members of each committee without vote.

9.3.2. Term, Removal and Vacancies: Committee members serve for a term of two years unless they resign or are removed, and they may succeed themselves in office. The MEC may remove any member from a committee by a majority vote. A committee vacancy is filled in the same manner as the member was appointed.

10. MEETINGS

10.1. Medical Staff Meetings

The President may call a meeting of the Medical Staff, in his or her discretion, as the need arises. He or she must call one if requested by the MEC or by at least 25 percent of Active Members.

10.2. Committee, Department and Section Meetings

10.2.1. Regular Meetings: Except as otherwise set forth in these Bylaws, committees, Departments and sections must meet as often as necessary to carry out their responsibilities. They may establish regular meeting dates and times by resolution, requiring no further notice.

10.2.2. Special Meetings: The chairperson of any committee, Department or section may call a special meeting and must call one when requested by the President, by the MEC or by at least 50 percent of the group's Active Members (but not fewer than two).

10.2.3. Executive Session: All committees, Departments and sections may sit in executive session and meet with only Members who are members of that committee present. A committee, Department or section chairperson, in his or her discretion, must permit the CEO or his or her designee to attend executive sessions.

10.3. Provisions Applicable to All Meetings

10.3.1. Notification of Meetings: Notification of all meetings (unless called by resolution) must be mailed, faxed, emailed or posted in a conspicuous place or personally delivered and state the date, time, place and purpose(s) of the meeting. Cancellation of regularly scheduled meetings should be given in the same manner.

10.3.2. Attendance: Members are strongly encouraged to attend as many Medical Staff meetings and meetings of the committees, Departments and sections of which they are members as possible.

10.3.3. Quorum: Attendance by 50 percent or more of the voting members of the MEC at a duly called or scheduled meeting is sufficient to conduct business. For all other duly called Medical Staff, Department, committee and section meetings, a quorum sufficient to conduct business consists of Members who attend and are eligible to vote (but not fewer than two).

10.3.4. Meeting Procedures

10.3.4.1. The President presides at Medical Staff meetings. The chairperson of a committee presides at committee meetings. Department or section chairpersons preside at their respective meetings.

10.3.4.2. The presiding official determines the order of business at a meeting. Suggested agenda items include approval of the previous meeting's minutes, reports, old business and new business.

10.3.4.3. Minutes of meetings or a summary must be prepared, reflecting attendance and business conducted. After approval by the meeting membership, the presiding official signs the minutes or summary, with copies provided to members upon request and made available, subject to confidentiality restrictions, to the Medical Staff. The Medical Staff Office will maintain a file of minutes and summaries for each Medical Staff, committee, Department and section meeting.

10.3.4.4. A majority vote of those present at a meeting at which quorum requirements are satisfied constitutes action of the group, unless these Bylaws provide differently. The chair may vote only in case of a tie. With the approval of the President and the CEO, a

group may meet and act by telephone conference or other electronic means as long as each member wishing to participate can hear the others and speak to the group when permitted. A group may also act without a meeting by unanimous written consent. "Unanimous written consent" includes an affirmative email reply expressing assent to a proposed action from each voting member of the group.

11. RESOLVING PROFESSIONAL COMPETENCE, CONDUCT OR DISCIPLINE ISSUES

11.1. Education and Improvement

The proper functioning of the Medical Staff requires that each Member ("Member" as used in this Article includes all Practitioners, unless context clearly limits application to a specific right or responsibility of Medical Staff Members only) cooperate with the Hospital, Medical Staff officers, Department and section chairpersons and Medical Staff committees in order to improve continuously individual and collective performance related to safety and quality of care. From time to time, these entities, functions or persons may need to hold routine discussions with individual Members in order to educate them, assist them in providing better quality medical care, help them be more valuable Medical Staff contributors or achieve performance improvement, resource management or other objectives of the Hospital. Neither these discussions nor the routine functioning of performance improvement, focused or ongoing professional practice evaluations, resource management or other programs, by themselves, are to be construed as "Investigations" of a Member.

11.2. Routine Corrective Actions

11.2.1. What Is Covered: Corrective action may be taken in accordance with the provisions of these Bylaws against a Member whose conduct is or may be:

11.2.1.1. Detrimental to the health, safety or welfare of any patient;

11.2.1.2. Below accepted standards of care within the Member's profession;

11.2.1.3. Disruptive to health-care facility operations or patient care;

11.2.1.4. Not in compliance with the Bylaws, Rules and Regulations or policies of the Medical Staff or of the Hospital; and

11.2.1.5. Without limiting the foregoing, violations of the following specific prohibitions:

11.2.1.5.1. Failure of a Member to provide a timely, adequate and appropriate consultation concerning the care of his or her patient;

11.2.1.5.2. Intentionally falsifying a medical record or intentionally providing false information respecting the care of any patient or any Medical Staff matter;

- 11.2.1.5.3. Soliciting patients;
 - 11.2.1.5.4. Unlawfully taking hospital property;
 - 11.2.1.5.5. Violating privileged communication between a Practitioner and a patient;
 - 11.2.1.5.6. Making false statements to another to discredit any Practitioner or Hospital employee;
 - 11.2.1.5.7. Fraudulent billing practices or the imposition of sanctions under any Federal health program;
 - 11.2.1.5.8. Interfering between another Member and his or her patient;
 - 11.2.1.5.9. Becoming addicted to drugs, becoming an alcoholic or developing any physical or mental condition, through advancing age or otherwise, such that continuing to practice at the Hospital would be dangerous to patients or others;
 - 11.2.1.5.10. Appearing at the Hospital impaired by drugs (including prescription or non-prescription drugs) or alcohol with the intention of participating directly or indirectly in patient care;
 - 11.2.1.5.11. Failing or refusing to submit to a physical or mental examination upon request, in accordance with the Rules and Regulations pertaining to the evaluation of potentially impaired Practitioners.
- 11.2.2. Who May Raise: A Department or section chairperson, Medical Staff officer, the CEO, the MEC or the Board (“Complainant”) may, upon his or her own knowledge or upon the knowledge of any third party, initiate an inquiry into the need for a corrective action.
- 11.2.3. How Handled: When a Complainant has reason to believe that a corrective action may be necessary:
- 11.2.3.1. Request: The Complainant (other than the MEC itself) submits a written request for an inquiry into the need for corrective action to the MEC, detailing the specific conduct that precipitates the request.
 - 11.2.3.2. Discussions: Before submitting the request, any Complainant may, but need not, discuss the matter with the Member. Such a discussion does not constitute an Investigation.
 - 11.2.3.3. When commenced: An Investigation does not begin until such time as the MEC formally declares that one has begun or as of the date the Board formally requests one in writing.

- 11.2.3.4. MEC Action Without Investigation: The MEC may recommend any action without first conducting an Investigation if it believes it has an adequate factual basis for doing so.
- 11.2.3.5. Investigation: If the MEC determines that an Investigation is warranted, it must conduct one.
- 11.2.3.5.1. The MEC may investigate on its own, or it may assign the task to an investigative ad hoc committee consisting of one or more persons. Ad hoc committee members need not be physicians, Members of the Medical Staff or associated with the Hospital.
- 11.2.3.5.2. The investigating committee, should it so decide, may request the attendance of the Member, upon reasonable Notice, for purposes of an interview.
- 11.2.3.5.3. No person who performs any part of an investigating committee may be in direct economic competition with the Member.
- 11.2.3.5.4. If a committee other than the MEC conducts the Investigation, it must submit a written report to the MEC detailing the results of the Investigation.
- 11.2.3.6. Opportunity to be Heard: Before making a recommendation that would constitute a Professional Review Action or any other disciplinary measure (except suspension), the MEC must extend a reasonable opportunity to the Member, by Notice, to be heard.
- 11.2.3.7. Not A Hearing: Neither initial discussions with the Member nor any subsequent interview, meeting or appearance under the above procedures constitutes a hearing and does not entitle the Member to any rights under the Fair Hearing Plan.
- 11.2.3.8. No Action Decision: Where there has been no Investigation (or if there is an Investigation that did not include an interview with the Member) and the MEC determines not to take any further action, the matter may be closed without further notice to the Member or Board.
- 11.2.3.9. Recommendation: Where the MEC determines to recommend any action other than no action at all (or there has been an interview with the Member), it must prepare a written recommendation with supporting documentation, sending a copy to the Member, either:
- 11.2.3.9.1. Concluding that the request is without merit and forwarding the MEC recommendation and documentation to the Board for ratification in accordance with the provisions of this Article;
- 11.2.3.9.2. Recommending no action, action that does not Affect Adversely the Member's membership or Clinical

Privileges or action that does not pertain to the Members competence or professional conduct and forwarding the recommendation and documentation to the Board for ratification in accordance with the provisions of this Article; or

11.2.3.9.3. Recommending the taking of a Professional Review Action, in which event it must give the Member Notice in accordance with the Fair Hearing Plan.

11.2.3.10. No member of the MEC may take part in the consideration or vote on the recommendation if he or she is in direct economic competition with the Member affected.

11.3. Summary Suspensions

11.3.1. Imposition: Any one of the following -- the MEC, the President, a Department/section chairperson or the CEO or designee -- may summarily suspend all or any part of a Practitioner's Medical Staff membership and Clinical Privileges where the failure to take such an action may result in an imminent danger to the health of any individual.

11.3.2. Notification: The persons taking action must promptly inform the Practitioner of a summary suspension by Notice. The suspension is effective immediately.

11.3.3. Care of Patients: The chairperson of the Department or section in which a suspended Practitioner holds Privileges must assure coverage by the Practitioner's alternate or, if necessary, arrange for appropriate alternate care, taking into account to the extent feasible the wishes of the patient.

11.3.4. Procedure After Notice: The act of imposing a suspension automatically commences an Investigation as of the date and time of imposition. The MEC, by itself or through an ad hoc committee, must conduct the Investigation. The MEC must then convene as soon as possible, and in no event later than 30 days after a summary suspension, to review the suspension's imposition. The MEC or an investigating ad hoc committee should make every effort to interview the Practitioner involved. Based upon the information reasonably available at the time of reconsideration, the MEC must take one of the following actions and notify the Practitioner of its decision:

11.3.4.1. Dissolve the suspension or modify it to an action that does not Affect Adversely the Practitioner's Medical Staff membership or Clinical Privileges and promptly forward its action to the Board for ratification. Such dissolution or modification has the effect of restoring all membership rights and Clinical Privileges, subject to further Board action or

11.3.4.2. Continue the suspension in effect as imposed or modify it as necessary where failure to continue the suspension may result in an imminent danger to the health of any individual. In addition or

in the alternative, the MEC may recommend the taking of a permanent Professional Review Action.

11.3.5. Special Procedure for MEC Suspensions: If the MEC is one of the suspending entities under 11.3.1, it may recommend a Professional Review Action and give the required notice of hearing pursuant to Section 11.3.6 below, without the need to reconvene and reconsider its own suspension, if it believes it has already conducted an adequate Investigation.

11.3.6. Right to a Hearing: If, following the reconsideration steps in Section 11.3.4, the MEC or the Board takes or recommends a Professional Review Action as a result of a summary suspension against a Practitioner, the acting body must give the individual prompt Notice of his or her right to request a hearing under the Fair Hearing Plan.

11.4. Automatic Suspensions

11.4.1. Imposition: A Member's Medical Staff membership and all Practitioner Clinical Privileges are automatically suspended, without further notice or action —

11.4.1.1. Immediately upon a restriction, limitation or lapse of a Practitioner's Kentucky license to practice or a restriction or involuntary limitation to his or her DEA registration, to the same extent as the restriction, limitation or lapse. When a limitation or restriction ends or a lapse has been cured, the Practitioner must reapply for each Privilege that was the subject of the restriction, limitation or lapse, in the same manner as provided in these Bylaws for reappointment. Lapsed licensure that lasts longer than 30 days converts the suspension into an Automatic Termination;

11.4.1.2. Immediately upon loss or failure to prove professional liability insurance coverage. Failures that last longer than 30 days convert the suspension into an Automatic Termination; and

11.4.1.3. Within seven days of notification to arrange for alternate coverage because of the withdrawal or disability of the currently designated covering Physician. Failure to provide alternate coverage within 30 days converts the suspension into an Automatic Termination.

11.4.2. Duration: Automatic Suspensions remain in effect for as long as the event(s) that gave rise to it remain uncured, or until conversion to an Automatic Termination, whichever occurs first.

11.4.3. Procedure to Challenge: A Practitioner may challenge the imposition of an Automatic Suspension in accordance with the procedures set forth below in Section 11.6 as the sole and exclusive remedy.

11.5. Automatic Termination

- 11.5.1. Events Resulting in Automatic Termination: The following events result, without further notice or action, in an Automatic Termination of a Member's Medical Staff membership and all Practitioner Clinical Privileges:
- 11.5.1.1. Conversion of an Automatic Suspension into an Automatic Termination in accordance with the terms of the Section;
 - 11.5.1.2. Revocation, suspension or denial of Kentucky license;
 - 11.5.1.3. Exclusion from a Federal Health Program;
 - 11.5.1.4. A Criminal Conviction;
 - 11.5.1.5. Failure without good cause of a Practitioner, after Notice, to appear at a meeting of the MEC, of an investigating committee or of the Board called to discuss the proposed taking of a Professional Review Action or any other disciplinary action;
 - 11.5.1.6. Failure to complete medical records in a timely manner as follows: A Practitioner must cure records deficiencies, as defined by Medical Staff policy, within the time specified in the policy following delivery of a notification identifying each deficiency requiring correction. If identified deficiencies remain uncorrected within that time, the CMO shall direct the Practitioner by Notice to attend the next MEC meeting. Failure to correct deficiencies within 48 hours after the MEC meeting results in Automatic Termination.
- 11.5.2. Procedure to Challenge: A Practitioner may challenge the imposition of an Automatic Termination in accordance with the procedures set forth below in Section 11.6 as the sole and exclusive remedy.

11.6. Challenging Automatic Suspensions and Automatic Terminations

- 11.6.1. Notice: The Medical Staff Office must give Notice to the Practitioner, with a copy to the Board, that an Automatic Suspension or Automatic Termination has occurred and of the grounds for it. The Practitioner has 10 days from receipt of the Notice to submit evidence to the MEC in writing negating the grounds for suspension or termination. Failure or delay in the giving of notice does not affect the validity of the suspension or termination.
- 11.6.2. MEC Review: The MEC must promptly meet and consider any evidence the Practitioner submits. The MEC's determination is final and is not subject to further review.
- 11.6.2.1. If the MEC determines that the grounds for suspension or termination did not exist, it must immediately restore the Practitioner to full Medical Staff membership or Clinical Privileges, as appropriate.

11.6.2.2. If the MEC determines that the suspension or termination grounds were valid, it must promptly give Notice to the Practitioner, with a copy to the Board, that the suspension or termination remains in effect. In the case of an Automatic Termination, the Notice must state that the Practitioner may, if he or she desires, reapply for such Membership or Privileges for which he or she may qualify.

11.6.3. No Hearing Right: Automatic Suspensions or Automatic Terminations do not entitle a Practitioner to any hearing or appeal rights other than the right to MEC review set forth in this section.

11.7. Board Ratification

11.7.1. If the MEC recommends action to the Board under this Article that does not Affect Adversely the membership or Clinical Privileges of a Practitioner --

11.7.1.1. and the Board approves the recommendation, it becomes final.

11.7.1.2. and the Board disagrees with the recommendation:

11.7.1.2.1. but takes action that is not a Professional Review Action, the decision is final.

11.7.1.2.2. and recommends action that would constitute a Professional Review Action, it must give the Practitioner Notice of his or her right to a hearing under the Fair Hearing Plan.

11.7.2. The Board must promptly notify the Practitioner and the MEC of any decision it makes under this Article.

12. FAIR HEARING PLAN

12.1. Requirements of a Professional Review Action

No Professional Review Action may be taken against a Member ("Member" in this Article includes AHPs) unless it is taken:

12.1.1. in the reasonable belief that the action was in the furtherance of quality health care,

12.1.2. after a reasonable effort to obtain the facts of the matter,

12.1.3. after the notice and hearing procedures in these Bylaws are afforded to the Member involved, or after such other procedures as are fair to the Member under the circumstances, and

12.1.4. in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the due process requirements of the preceding paragraph.

12.2. Right to a Hearing

12.2.1. A Member has a right to a hearing under this Fair Hearing Plan if the MEC or the Board takes or recommends a Professional Review Action against the Member.

12.2.2. A Member has no right to a hearing under this Fair Hearing Plan where the action will not Adversely Affect his or her Medical Staff membership or Clinical Privileges or where the action does not relate to competence or professional conduct. Such actions include, but are not limited to warning letters or letters of reprimand.

12.2.3. The right to a hearing following a summary suspension is defined in Section 11.3.4.

12.3. Notice of Right to Hearing

12.3.1. If a Member is entitled to a hearing, the body that took action or made the recommendation must give the Member prompt Notice telling the Member:

12.3.1.1. that an action Adversely Affecting the Member has been taken or is proposed to be taken;

12.3.1.2. the specifics of the action Adversely Affecting the Member and the reasons for it;

12.3.1.3. that the Member has 30 days following the Notice within which to request a hearing, which request must be by Notice to the CEO or his or her designee (reference throughout this Article to CEO means CEO or designee);

12.3.1.4. that if he or she does not file a timely request for a hearing, he or she waives all hearing and appeal rights to review the action; and

12.3.1.5. that he or she has the rights at the hearing specified in this Fair Hearing Plan, a copy of which must be included with this Notice.

12.3.2. If the Member does not request a hearing within 30 days after receiving the Notice under this section, he or she is deemed to have consented to the action or proposed action and to have waived all further hearing and appeals rights under this Fair Hearing Plan.

12.3.3. In the event of a Member waiver of hearing and appeal rights, the CEO must forward the action Adversely Affecting the Member to the Board for approval.

12.4. Notice of Hearing and Lists of Witnesses

12.4.1. If a Member makes a timely request for a hearing, the CEO must promptly forward the request to the President. The President, in consultation with the CEO, must promptly arrange and schedule a hearing. The CEO must then give prompt Notice to the Member setting forth:

12.4.1.1. the place, time and date of the hearing, which date may not be fewer than 30 days after the date of this Notice;

12.4.1.2. a list of the witnesses, if any, that the institution expects will testify on its behalf at the hearing; and

12.4.1.3. a statement that if he or she does not personally appear at the hearing, he or she forfeits all rights to a hearing and appeal.

12.4.2. The Member must provide to the CEO, not later than seven days prior to the hearing, a list of witnesses that the Member expects will testify on his or her behalf.

12.5. The Hearing Panel or Officer

12.5.1. The hearing may be conducted by a panel of not fewer than three or more than five persons or by a hearing officer, appointed by the President in consultation with the CEO. Hearing panel members or the hearing officer must be impartial peer physicians but need not be Medical Staff Members. No hearing panel member or hearing officer may be in direct economic competition with the Member, play any part in presenting the case against the Member or have participated in investigating or deciding a prior phase of the case. Prior knowledge of the facts is not a disqualifying circumstance.

12.5.2. The President must designate one of the panel members as chairperson, who presides at the hearing. The chairperson or hearing officer:

12.5.2.1. must act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence and that decorum is maintained;

12.5.2.2. determines the order and procedure during the hearing, makes rulings on admissibility and relevance of evidence and may set reasonable time limits for the hearing; and

12.5.2.3. may, in his or her sole discretion, hold a pre-hearing conference to simplify or clarify the issues to be heard, resolve disputes, facilitate settlement, specify the timing and order of witnesses and address any other matter that may facilitate the just, speedy and inexpensive disposition of the hearing.

12.5.3. The hearing panel or officer may retain counsel (to be selected and paid by the Hospital) to assist it in conducting the hearing and in preparing the hearing report and recommendation.

12.6. Conduct of the Hearing

- 12.6.1. The Member requesting the hearing must appear in person. He or she forfeits his or her right to the hearing and all appeals if he or she fails, without good cause, to appear.
- 12.6.2. The MEC or the Board -- whichever body took or recommended the Professional Review Action -- must appoint a person who is not in direct economic competition with the Member to represent it at the hearing.
- 12.6.3. At the hearing the Member and the institutional representative have the following rights:
 - 12.6.3.1. To representation by an attorney or other person of his or her choice;
 - 12.6.3.2. To have a record made of the proceedings, copies of which may be obtained by the Member upon payment of any reasonable charges associated with the preparation thereof;
 - 12.6.3.3. To call, examine and cross-examine witnesses;
 - 12.6.3.4. To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and
 - 12.6.3.5. To submit a written statement at the close of the hearing.
- 12.6.4. The Member bears the burden of proof, including the burden of producing evidence and the burden of persuading the hearing panel or officer, by clear and convincing evidence, that the action Adversely Affecting the Member is arbitrary, capricious, unreasonable or against the weight of the evidence.
- 12.6.5. The hearing panel need not conduct the hearing strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence.
- 12.6.6. Should the Member elect not to testify on his or her own behalf, the Hospital representative may nevertheless call the Member to testify as if on cross-examination.
- 12.6.7. The hearing panel may, in its sole discretion, recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.
- 12.6.8. Upon conclusion of the presentation of evidence and the submission of written statements, if any, the hearing is closed. The panel, at a time convenient to itself, conducts its deliberations outside the presence of the Member.

12.7. The Report and Recommendation

- 12.7.1. Within 15 days after the hearing closes (or as soon thereafter as is reasonably possible), the hearing panel or officer must make and deliver a written report and recommendation confirming, modifying or rejecting the adverse recommendation or decision under review. This report must contain the bases for the recommendation. If the report recommends taking an action Adversely Affecting the Member, it must detail the respects in which the recommendation meets the requirements of Section 12.1.
- 12.7.2. The hearing panel or officer must promptly give Notice enclosing its written report and recommendation to the Member; to the Hospital representative; to the CEO; to the President; to the MEC; and to the Board.
- 12.7.3. The MEC must make a final recommendation to the Board in writing within 10 days of receipt of the Notice from the hearing panel or officer. The final recommendation may adopt the hearing panel's recommendation, modify that recommendation or reject that recommendation. Should the MEC modify or reject the recommendation, it must provide written reasons in its final recommendation. The MEC must then promptly give Notice to the Member enclosing its final recommendation. Failure of the MEC to act within 10 days shall be deemed to be a final recommendation of adoption of the hearing panel's report and recommendation, and the CEO shall give prompt Notice to the Member; to the Hospital representative; to the President; to the MEC; and to the Board. Notices required by this subsection must include a proposed report to the National Practitioner Data Bank report drafted by the Hospital.
 - 12.7.3.1. If the final recommendation Adversely Affects the Member's membership or Privileges, the Member is entitled to an appeal under the Appellate Review section below.
 - 12.7.3.2. If the final recommendation does not Adversely Affect the Member's membership or Privileges,
 - 12.7.3.2.1. and the Board agrees, the Board's decision is final.
 - 12.7.3.2.2. and the Board preliminarily determines to take an action that Adversely Affects the Member's membership or Privileges, the Board must give Notice of such intention, with reasons, to the Member, and the Member is entitled to an appeal under the Appellate Review section below.

12.8. Appellate Review

- 12.8.1. The Member may appeal a final MEC recommendation that Adversely Affects his or her membership or Privileges or a Board determination under the preceding section by giving Notice of intent to seek appellate review to the CEO within 15 days of receipt of Notice of the MEC's final recommendation or Board determination. The Notice shall set forth the bases for the appeal.

- 12.8.2. Failure to give Notice of appeal within 15 days results in a waiver of the Member's appeal rights, in which event the final recommendation of the MEC becomes final when approved by the Board. Should the Board propose a final determination that is more adverse than the MEC recommendation, the Member may appeal that proposed determination within 15 days of receipt of Notice of such proposal. Notice to seek review of the proposed determination must be given to the CEO.
- 12.8.3. Within 10 days of a Member's Notice of appeal, the MEC may submit a written statement setting forth its position on appeal. The MEC shall provide the statement in a Notice to the Member, the President, the CEO, the MEC and the Board.
- 12.8.4. An Appellate Review Committee of at least three Board members appointed by the Board chairperson conducts the appellate review. No member of the Appellate Review Committee may be in direct economic competition with the Member, play any part in the presentation of the appeal or have participated in any earlier Investigation or decision of the matter.
- 12.8.5. The Appellate Review Committee may establish the procedure to be used during appellate review on a case-by-case basis as the committee in its sole discretion deems necessary in order to properly narrow the issues and decide the appeal fairly. Such procedures may include, without limitation, whether to solicit, accept or limit further written statements; whether to schedule or permit oral argument; whether to require the presence of or to question the Member; and whether to accept or consider new or additional evidence not presented at the hearing.
- 12.8.6. The appellate decision may affirm the final recommendation of the MEC, or it may modify or reverse the recommendation or remand the matter back for the taking of additional evidence if and to the extent that:
 - 12.8.6.1. the hearing panel or officer failed to follow proper hearing procedures; or
 - 12.8.6.2. the recommendation of the hearing panel or officer was arbitrary, capricious, unreasonable or against the weight of the evidence.
- 12.8.7. Within 15 days after the conclusion of the appellate review or as soon thereafter as reasonably possible, the Appellate Review Committee must render a decision, including the bases for the decision, and deliver a copy by Notice to the Member; to the Hospital representative; to the CEO; to the President; and to the Board. If the decision directs the taking of an action Adversely Affecting the Member, it must detail the respects in which the decision meets the requirements of Section 12.1.
- 12.8.8. A decision of the Appellate Review Committee affirming, modifying or reversing the recommendation(s) of the hearing panel is final when approved by the Board. If the decision Adversely Affects the membership or Privileges of the Member for more than 30 days, the Board must, after consultation with the President or his/her designee, approve or amend, as appropriate, the proposed National Practitioner Data Bank report and

direct the CEO to file it with the appropriate authorities. Should the Appellate Review Committee remand the matter back for the taking of additional evidence, the Member may appeal the resulting recommendation in accordance with the provisions of this Section 12.8.

12.9. Reporting Requirements

The Hospital must report to the National Practitioner Data Bank:

- 12.9.1. Each final Professional Review Action that Affects Adversely the Clinical Privileges or Medical Staff membership of a Physician for a period in excess of 30 days; and
- 12.9.2. Each surrender of Clinical Privileges or Medical Staff membership by a Physician
 - 12.9.2.1. while the Physician is under Investigation; or
 - 12.9.2.2. in return for not conducting an Investigation.

12.10. Miscellaneous

- 12.10.1. Except as provided in the last sentence of Section 12.8.8, no Member is entitled to more than one hearing and one appeal on any matter.
- 12.10.2. Except for (i) the time to request a hearing and (ii) the time to request an appeal, the time periods in this Fair Hearing Plan may be extended or shortened by mutual agreement.

13. ALLIED HEALTH PROFESSIONALS

13.1. General Provisions Applicable to all AHPs

- 13.1.1. There are two types of AHPs: Privileged AHPs and Authorized AHPs. The provisions of this section apply to all AHPs.
- 13.1.2. AHPs must hold a current Kentucky license, certificate or registration (if available) appropriate to the care they will provide and professional liability insurance in an amount and with a carrier satisfactory to the Board.
- 13.1.3. AHPs are not Members of the Medical Staff and have none of the rights or privileges of Medical Staff membership.
- 13.1.4. Except for Podiatrists, Dentists and Clinical Psychologists, who may practice without supervision, a Medical Staff Member must supervise each AHP. No supervised AHP may exercise Privileges or authority that is broader than the Privileges held by the supervising Member.

- 13.1.5. AHPs are assigned to a Department or section and are subject to the ultimate supervision and control of the Department or section chairperson and to the rules of the Department or section.
- 13.1.6. AHPs are subject to all provisions of these Bylaws, of the Rules and Regulations and Policies of the Medical Staff (unless context clearly limits application to a specific right or responsibility of a Medical Staff Member) and to the rules and regulations and policies of the Hospital. AHPs may provide patient care services only within the scope of their Kentucky licensure, certificate or registration and delineated Privileges or scope of practice document.
- 13.1.7. AHPs may not admit or discharge patients;
- 13.1.8. AHPs may serve on Medical Staff, Department and section committees but have no voting rights.

13.2. Privileged AHPs

- 13.2.1. Privileged AHPs Defined: Privileged AHPs are Advanced Practice Nurses (Advanced Registered Nurse Practitioners, Certified Registered Nurse Anesthetists and Certified Nurse Midwives), Physician Assistants, non-surgical Podiatrists, surgical Podiatrists who first receive podiatric surgery Privileges after the effective date of these Bylaws, Perfusionists, Dentists who have not completed an accredited post-graduate training program and Clinical Psychologists. Privileged AHPs may, but need not, be employees or independent contractors of the Hospital.
- 13.2.2. Clinical Privileges Required: Privileged AHPs must submit a KAPER application and apply for and receive Clinical Privileges before providing patient care, treatment or services. They must document their status, education, training, experience, competence and ability to perform the Clinical Privileges they seek. Applications for Privileges and privilege renewals are filed and processed in the same manner as applications by Members.
- 13.2.3. Term of Privileges: Clinical Privileges to a Privileged AHP may not exceed two years.
- 13.2.4. Appraisal: Privileged AHPs are subject to the same quality monitoring mechanisms as Medical Staff Members, including focused and ongoing professional practice evaluations.

13.3. Authorized AHPs

- 13.3.1. Authorized AHPs Defined: Authorized AHPs are practitioners, other than Medical Staff Members and Privileged AHPs, who are licensed, registered or certified (if available) by Kentucky to provide such care, treatment or services as the Medical Staff may recommend and the Board may approve. A current list of Authorized AHPs appears in the Credentialing Manual. Authorized AHPs may not be employees or independent contractors of the Hospital.

- 13.3.2. Application for Authority: Applicants for authority to practice as an Authorized AHP must submit a KAPER application and an appropriate scope of practice document that describes the care, treatment or services the Authorized AHP seeks to provide. They must document their status, education, training, experience, competence and ability.
- 13.3.3. Processing Applications: Upon receipt of an application, the Medical Staff Office will conduct primary source verification in the same manner as for Members. The CMO, the chair of the Department or section to which the Authorized AHP will be assigned and the Credentials Committee will each review the application file in turn and make a recommendation. Any body or person may request additional information to verify the applicant's qualifications. Recommendation by the MEC and approval by the Board is necessary for authority to practice.
- 13.3.4. Term of Authority: The term of authority granted to an Authorized AHP may not exceed two years.
- 13.3.5. Appraisal: Each year, the Authorized AHP's supervising Member must conduct an appraisal of the AHP's competence and professional conduct. Such appraisal must include a review of the scope of practice document to verify compliance, completeness and continued relevance. The supervisor must provide written results of the appraisal to the Department or section chairperson and to the MEC.

13.4. Professional Review Actions Against Allied Health Professionals

- 13.4.1. Before the Hospital may take a Professional Review Action that affects adversely the Clinical Privileges or scope of authority of an AHP, the AHP is entitled to the hearing and appeal procedures of the Fair Hearing Plan.
- 13.4.2. The limitation or termination of Privileges of a supervising Member results in a comparable limitation or termination of the Privileges or scope of authority of the AHPs he or she supervises. Such a limitation or termination is not a Professional Review Action and does not entitle the AHP to any hearing or appeal rights.

14. CONFIDENTIALITY, IMMUNITY AND RELEASE

By submitting an application for Medical Staff appointment or a request for Clinical Privileges, each Practitioner agrees to be bound by the specific provisions of this Article.

14.1. Information Collection and Handling

- 14.1.1. Third parties are specifically authorized to release information about a Practitioner's qualifications to Hospital Representatives.
- 14.1.2. Hospital Representatives are specifically authorized to release information about a Practitioner's qualifications to other hospitals, health-care entities, authorized health-care licensing, data collection or reporting agencies in

the course of credentialing or licensing activities or to the extent required or permitted by law.

14.2. Confidentiality in Professional Review Activities

- 14.2.1. Practitioners who serve Professional Review Bodies are entitled to preserve the confidentiality of their Professional Review Activities from disclosure to reviewed Practitioners and to others in order to foster candid and complete assessments of professional qualifications. Practitioners whose qualifications are reviewed are likewise entitled to the confidentiality and disclosure of information about them to others only in the manner permitted by law and by these Bylaws.
- 14.2.2. Practitioners are forbidden to disclose Peer Review Matter to any other person, except as expressly provided in this section.
- 14.2.3. Except for disclosure authorized by Section 14.2.1, Peer Review Matter may be disclosed to others only:
 - 14.2.3.1. as may be permitted or required by law or by a court of competent jurisdiction; or
 - 14.2.3.2. as may be specifically authorized in a written consent by both the Practitioner and the unanimous approval of the Professional Review Body.

14.3. Immunity and Release

- 14.3.1. Each of the following persons acting in good faith is immune from civil liability for damages or other relief, and each Practitioner specifically releases:
 - 14.3.1.1. Each person who provides information to a Hospital Representative in furtherance of a Professional Review Activity;
 - 14.3.1.2. Each Hospital Representative who participates in a Professional Review Activity, including, but not limited to, each Professional Review Body; each person acting as a member or staff to the body; each person under contract or other formal arrangement with either a Hospital Representative or the body; and each person who participates with or assists the body; and
 - 14.3.1.3. Each third person to whom a Hospital Representative releases information.
- 14.3.2. In the event that a Hospital Representative takes or investigates the taking of a Professional Review Action, each Practitioner agrees to exhaust all steps set forth in these Bylaws, including administrative review and the exercise of his or her rights, if any, under the Fair Hearing Plan as his or her exclusive remedy respecting that action.
- 14.3.3. The immunities provided in this Article are cumulative and do not limit or restrict immunities that are otherwise available under law.

14.4. Indemnity

A member of the Medical Staff who has been sued for a good faith act or omission in the course of and within the scope of his or her authorized activities as an officer of the Medical Staff or as chairperson or member of a committee, Department or section shall be provided coverage under Hospital's professional liability self-insurance program, subject to all terms, provisions, and exclusions contained therein.

15. RULES AND REGULATIONS AND POLICIES

15.1. Generally

The Medical Staff must adopt and amend Rules and Regulations and policies as necessary to implement more specifically the general principles found in these Bylaws.

15.2. How Adopted or Amended

15.2.1. The MEC may adopt or amend Rules and Regulations or policies on its own initiative.

15.2.2. In the alternative, the Medical Staff may propose adoption or amendment of Rules and Regulations or policies by presentation of a written petition to the MEC signed by at least 15 Members eligible to vote detailing each proposed change. Action by the MEC on changes to the Rules and Regulations and policies proposed in this manner is final. The MEC must publicize each proposed Rules and Regulations change prior to action.

15.2.3. In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff. In such a case, the MEC must immediately notify the Medical Staff of the amendment and offer a reasonable opportunity to Members to review and comment on the amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, Members and MEC must resolve it in accordance with the provisions of Article 9.2 pertaining to the management of conflicts and resubmit the change to the Board.

15.3. Publicizing Changes; Final Approval; No Unilateral Change

The MEC must publicize all Rules and Regulations and policy changes it approves. Rules and regulations and policies are effective upon approval by a majority vote of the Board. Neither the Medical Staff nor the Board may adopt or amend Rules and Regulations or policies unilaterally.

16. ADOPTION AND AMENDMENT

16.1. Responsibility

The Medical Staff has the responsibility to formulate and propose Bylaws and Bylaws amendments and to review and revise them when necessary to reflect current practice with respect to Medical Staff organization and functions. It must exercise this responsibility in good faith and in a reasonable, responsible and timely manner. Bylaws are not effective until both the Medical Staff and the Board approve them. Neither may amend the Bylaws unilaterally.

16.2. Procedure

All Bylaws amendments must first be submitted to and considered by the Bylaws Committee, which submits its proposals to the MEC. The MEC must then circulate or make available to Members eligible to vote all changes it recommends. Approval by two-thirds of those eligible voting Members who return a mail ballot within 14 days constitutes approval by the Medical Staff. Approval by a majority of the Board constitutes approval by the Board.

16.3. Alternate Procedure for Adoption or Amendment

Members of the Medical Staff who want to propose the adoption or amendment of any Bylaws provision may bypass the provisions of Section 16.2 and proceed as follows:

- 16.3.1. Members must hold a special meeting called in accordance with Bylaws Section 10.1.
- 16.3.2. Members calling the meeting must provide notification of the meeting in accordance with Bylaws 10.3.1.
- 16.3.3. A quorum of 50 percent of the voting Medical Staff Membership must appear and participate. Proxy voting is not permitted.
- 16.3.4. Approval by two-thirds of eligible voting members who appear at the meeting constitutes approval of the Medical Staff. Approval by a majority of the Board constitutes approval by the Board.

16.4. Adoption

The adoption of these Bylaws supersedes:

- 16.4.1. The St. Elizabeth Medical Center document called Medical-Dental Staff Constitution, Bylaws & Rules and Regulations and Allied Health Professionals Bylaws, last revised September 11, 2006, to the following extent: Preamble, Constitution of the Medical-Dental Staff and Bylaws of the Allied Health Professionals;
- 16.4.2. The St. Luke Hospitals document called Bylaws of the Medical Staff of St. Luke Hospital, Inc., last approved by the Medical Staff on November 20, 2006 and by the St. Luke Board of Directors on October 19, 2006 to the following extent: The Preamble, Definitions and Bylaws Articles I through XV and the Fair Hearing Plan; and
- 16.4.3. All Rules, Regulations and policies inconsistent with these Bylaws.

AMENDMENTS APPROVED by the St. Elizabeth Healthcare Medical Staff on _____, 2010.

President
St. Elizabeth Healthcare Medical Staff

AMENDMENTS APPROVED by the Board on _____, 2010.

Chair, Board of Trustees
Saint Elizabeth Medical Center, Inc.