WILLIAM NEWTON HOSPITAL

MEDICAL STAFF BYLAWS

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WILLIAM NEWTON HOSPITAL

Medical Staff Bylaws

PREAMBLE AND DEFINITIONS

1. The William Newton Memorial Hospital (a.k.a. WNMH, William Newton Hospital, WNH or Hospital) is organized under K.S.A., 12-1615, governed by the Board of Trustees appointed by the City of Winfield, Kansas and established for the purpose of providing healthcare services. To fulfill this purpose, the Board acting upon Medical Staff recommendations, appoints a staff of practitioners and allied health professionals.

2. In return for the privileges of utilizing Hospital services to care for patients, the practitioners and professionals on staff accept the obligation to provide medically effective and prudent care. To this end, these practitioners and professionals shall be organized as the William Newton Hospital Medical Staff.

3. The WNH Medical Staff, acting on authority of the Board and in compliance with state and federal law, provides the mechanisms whereby:

   a. The Board is assured of medically effective and safe performance by the Medical Staff members; and,

   b. Medical Staff members are assured of group input into the decisions, policies and plans of William Newton Hospital, and that a suitable environment is available to provide quality care to their patients.

4. This document describes the relationship and characteristics of:

   a. The WNH Medical Staff's obligation to the Board;

   b. Prerogatives which may be exercised by the WNH Medical Staff and the individual members to accomplish the required functions;

   c. Safeguards which protect the rights and privileges of individual staff members;

   d. Safeguards which protect the patients, employees and assets of WNH;

   e. Organizational details (such as committees, departments, officers, service chiefs, etc.);

   f. Definitions to clarify various terms;

   g. Provisions that specify many, but not all, of the operational policies associated with providing patient care at WNH.

DEFINITIONS

1. *Allied Health Professional (AHP)* means an individual with medical related credentials who is not a physician, dentist or podiatrist regardless of privileges to act independently or employment status (see Art. III).

2. *Attending Physician* means the practitioner who admits the patient for care, regardless of whether inpatient or outpatient. Attending status can be formally transferred to another practitioner if ordered in the patient record and accepted by the practitioner who will assume care of the patient. The attending physician is ultimately responsible for directing the care of the patient and completing the history and physical.

3. *Board of Trustees* means the governing body of William Newton Hospital, members who are appointed to the Board by the City Commission in accordance with City of Winfield Ordinance sections 3-301 et. seq. The terms Board, Governing Board and Governing Body are synonymous with Board of Trustees.

4. *Chief Executive Officer (CEO)* means the individual appointed by the Board to act on its behalf in the overall management of the Hospital. The Chief Executive Officer may appoint representatives to perform certain administrative duties identified in these Bylaws.

5. *Chief of Service* means a Medical Staff member who has been appointed in accordance with these Bylaws and has the qualifications and responsibilities for administration of the specified clinical services.

6. *Clinical Privileges or Privileges* means permission granted by the Board, acting on Medical Staff recommendations, to render specific types of care to patients in William Newton Hospital.

7. *Clinical Service* means a grouping of practitioners and/or allied health professionals according to clinical activities and privileges.

8. *Corporate Compliance Plan* means the WNH Corporate Compliance Plan and any related policies and procedures adopted by the Board to promote Hospital's compliance with applicable laws and regulations (see Article XIII).

9. *Medical Executive Committee* (MEC) means the medical executive committee of the WNH Medical Staff.

10. *Ex Officio* means by virtue of an office or position held, with all rights and privileges of other members, except this person may not chair or vote at a Medical Staff general or committee meeting.

11. *Good Standing* means the staff member, at the time the issue is raised, has met the attendance and committee participation requirements during the previous medical staff year, and has not received a suspension or restriction of his or her appointment, admitting or clinical privileges in the previous twelve (12) months; provided, however, that if the staff member has been suspended in the previous twelve (12) months for failure to comply with Hospital's policies or regulations regarding medical records and has subsequently taken appropriate corrective action, such suspension shall not adversely affect the staff member's good standing status.

12. *Guidelines* mean that the information is recommended by the Medical Staff as good practice but is not required.

13. *Hearing Committee* means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner or Allied Health Professional in accordance with Article VI of these Medical Staff Bylaws.

14. *Hospital* means the legal organization and physical facility of William Newton Memorial Hospital (a.k.a. WNMH, William Newton Hospital or WNH) located in Winfield, Kansas and all off-campus operations (e.g. rural health clinics, occupational health sites) where applicable.

15. *Impaired Professional* (see article XIII).

16. *Licensed Independent Practitioner* means a practitioner or specified allied health professional who is licensed by the State of Kansas and granted clinical privileges by Hospital to function independently.

17. *Medical Staff* means the group of medical practitioners and those allied health professionals who are credentialed by the Board and who provide healthcare services in the William Newton Hospital, subject to the provisions of these Bylaws.

18. *Medical Staff Appointment* means appointment to the William Newton Hospital Medical Staff, assignment to a staff category and assignment to a clinical service. Medical staff appointment does not automatically confer specific clinical privileges.

19. *Medical Staff Appointments will commence on the day that the initial application is approved by the Board of Trustees (unless otherwise indicated) and will end two years after the initial appointment date, or on a date prior to two years from the initial appointment date.*

20. *Member* means any practitioner or allied health professional who meets the criteria within these Bylaws, has applied for membership, been recommended by the Executive Committee and approved by the Board of Trustees regardless of privileges granted.

21. *Mid Level Practitioner* (MLP) or Advanced Practice Practitioner (APP) means an allied health professional (see #1), including Registered Physician Assistant (PA-C) , Advanced Practice Registered Nurse (APRN), Certified Registered Nurse Anesthetist (CRNA) and Certified Nurse Midwife (CNM). See also Rules and Regulations Section 9.

22. *Peer Review Committee* means a committee identified in the Hospital's Risk Management Plan as conducting formal peer review for the purposes set forth and more fully described in K.S.A. Sections 65-4915 and 65-4923, as amended.

23. *Practitioners* mean those physicians (MD's and DO's), dentists and podiatrists who are granted clinical privileges to provide services to patients of William Newton Hospital subject to these Bylaws.

24. *Prerogative* means the right to participate, by virtue of Medical Staff membership category or privileges granted to a staff member, and subject to the ultimate authority of the Board and the

conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

25. *Rules and Regulations* mean the rules and regulations adopted by the Medical Staff and approved by the Board as supplemental to and consistent with these Bylaws.

26. *Special Notice* means a written notification sent via United States Postal Service, certified or registered mail, with return receipt requested, to the address of the person to be notified. Special notice may be deemed effective by personal delivery to the person to be notified.

Revised 6/2021

WILLIAM NEWTON HOSPITAL
Medical Staff Bylaws

Article I
Name, Purposes and Responsibilities

1. *Name*

The name of the organization shall be the Medical Staff of William Newton Hospital, Winfield, Kansas. This is not a separate or independent organization; rather it is an organized group within the Hospital.

2. *Purposes*

The purposes of the Medical Staff are:

a. To be accountable to the Board for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner and Professional appointed to the Medical Staff and to promote patient care at Hospital that is consistent with generally recognized standards of care;

b. To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual members and the obligations of the Medical Staff may be fulfilled;

c. To provide an appropriate and efficient forum for Medical Staff member input to the Board and Administration on Hospital and medical issues.

3. *Responsibilities*

The Medical Staff's responsibilities shall include:

a. Participate in the performance improvement, quality review, and utilization management of the Hospital and conduct activities required by the Hospital to assess, maintain and improve the quality and efficiency of medical care in the Hospital, including without limitation:

i. Evaluate Medical Staff members and institutional performance using clinically sound criteria;

ii. Monitor critical patient care practices on an ongoing basis;

iii. Establish criteria for evaluating credentials during appointment and reappointment to the Medical Staff and for granting clinical privileges that are assigned to individual members;

iv. Initiate and pursue corrective action with respect to Practitioners and Professionals when warranted; and

v. Identify and promote the appropriate use of Hospital resources available for meeting patients' medical, social, and emotional needs, in accordance with sound

resource utilization practices.

b. Make recommendations to the Board regarding Medical Staff appointment and reappointment, including category and service assignments, clinical privileges, and corrective and/or disciplinary action.

c. Assist in the development, delivery and evaluation of continuing medical education and training programs.

d. Develop and maintain Medical Staff Bylaws and policies that promote sound professional practices, organizational principles and compliance with federal and state law requirements and to enforce compliance with Medical Staff Bylaws and policies.

e. Participate in the Hospital's long-range planning activities, to assist in identifying community health needs and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

f. Fulfill the obligations and appropriately use the authority granted in these Medical Staff Bylaws in a timely manner through the use of Medical Staff officers, committees and responsible individuals.

g. Assure that at all times at least one physician member of the Medical Staff is on duty or available within a reasonable period of time for emergency service.

Reviewed 6/2021

Article II
Medical Staff Membership

1. *Eligibility*

Applicants for Medical Staff appointment and reappointment:

a. Must be currently licensed in the State of Kansas;

b. Must provide evidence of training, experience, current clinical competence, good reputation and moral character, and physical, mental and emotional stability, as required by the provisions of these Bylaws;

c. No applicant shall be entitled to membership or privileges on the Medical Staff merely by the virtue of employment, residence, license in Kansas or any other state, or membership in any professional organization, having membership or privileges at another hospital, or previous membership or privileges at WNH;

d. No applicant shall be denied membership or privileges on the basis of gender, race, creed, color, national origin, ancestry, age, sexual orientation or physical disability. Applicant must be able to perform the duties generally associated with the privileges requested and others herein with reasonable accommodations.

2. *Initial Application*

Each applicant will provide at least the following information in writing:

a. Names of at least three (3) professional references from the discipline, or related disciplines, who have worked with the applicant and observed professional performance, and who can provide evidence as to the applicant's clinical ability and ethical character;

b. Verified information regarding professional school diploma, board certifications and numbers, DEA number and membership in local, state or national professional societies;

c. Information as to whether any professional registration, license or medical staff appointment or clinical privileges at another hospital have been denied, reduced, revoked, suspended, not renewed, voluntarily relinquished or challenged;

d. Information on the applicant's physical and mental health;

e. Information about current professional liability insurance coverage and all information on malpractice judgments, and/or settlements, including consent to the release of information by past and present malpractice insurance carriers;

f. Information on any criminal record, including arrests or convictions of misdemeanor or felony crimes;

g. Disclosure in writing of any potential conflicts of interest, including any ownership or contractual interest the member (or immediate family members) may have with the Hospital or its related entities, suppliers, vendors, or contractors.

h. Any additional information reasonably required by the Medical Staff, Administration, or Board to adequately evaluate the applicant.

3. *Applicant's Agreement*

Each applicant for Medical Staff appointment or reappointment:

a. Agrees to be bound by these Bylaws, including the Medical Staff Rules and Regulations (each applicant receives a copy of the Medical Staff Bylaws, Rules and Regulations);

b. Is willing to appear for an interview as part of the application process if requested;

c. Authorizes Hospital representatives and members of the Medical Staff to obtain validation of information supplied in support of the application;

d. Releases from liability all Hospital trustees, employees and representatives, and members of the Medical Staff who evaluate the applicant's qualifications in good faith and without malice;

e. Releases from liability all individuals and organizations who, in good faith and without malice provide information relevant to the application;

f. Is responsible for the truth, accuracy and completeness of information provided;

g. Agrees to pay any dues or fines that may be approved by the Medical Staff;

h. Acknowledges the applicant's obligations to provide continuous care and supervision of patients;

i. Agrees to demonstrate professional behavior and to work harmoniously with peers and others who are essential to quality patient care;

j. Agrees to abide by the conduct principles of the Medical Staff and individual's professional discipline;

k. Agrees to reasonably assist with Medical Staff functions based on membership category and expertise, including but not limited to serving on committees and attending meetings.

4. *Applicant's Responsibility for Complete Application*

The applicant shall have the burden of providing the required information pertaining to the Medical Staff application and for obtaining validation of information provided. Processing of the application cannot begin until all required information is on file and validated. The applicant will be notified when the application is not complete.

5. *Appointment Process*

a. The application, forms and a copy of the Medical Staff Bylaws, Rules and Regulations must be obtained from the Chief Executive Officer (CEO).

b. The National Practitioner Data Bank is queried as well as other verification agencies when appropriate.

c. After collecting the references and other pertinent materials, the application and all supporting material shall be transmitted to the Medical Executive Committee (MEC) for evaluation and recommendation.

6. *Recommendation Process*

The MEC recommendations must include the category of staff membership and the clinical privileges to be assigned to the applicant.

a. The MEC acts on completed applications, including references and verifications, within thirty (30) days of receipt of complete application; the Board of Trustees acts on the MEC's recommendation within sixty (60) days thereafter.

b. The recommendation may be deferred and additional information requested. It may not be deferred for more than sixty (60) days.

c. If the recommendation is to reject the application, specific reasons must be clearly documented.

d. The MEC shall consider recommendations from the appropriate clinical service or committee and all other recommendations and other relevant material available to it. The MEC shall forward its recommendation to the Board of Trustees. The Board of Trustees makes the final decision on the appointment, in accordance with the Bylaws, Rules and Regulations of the Hospital and Medical Staff.

e. Initial appointments shall be provisional for a period of six months. Reappointment shall be for a period of not more than two years.

f. The appointee will be notified within ten (10) days in writing by the CEO of the Board of Trustees' action.

7. *Reappointment and Renewal of Privileges*

Information about the member's performance and competency shall be provided to the MEC and Board of Trustees, including:

a. The CEO shall, at least sixty (60) days prior to the expiration date of the present staff appointment, provide each member with an interval information form for use in renewal of appointment and privileges. The member shall return the interval information form at least thirty (30) days prior to the membership expiration date. The interval information form may include the following:

i. Request to continue or change present Medical Staff status, clinical privileges, or staff assignment;

ii. Explanation of continuing training, education and experience that qualifies staff member for privileges requested on reappointment;

iii. Updated information regarding awards, recognition, honors, articles published, appointments, and other professional activities;

iv. Any sanctions imposed by any other healthcare institution, professional organization or licensing authority;

v. Current malpractice insurance coverage and status of any claims, suits and settlements;

vi. Peer recommendations from the clinical services to which the member is assigned;

vii. Specific information concerning the member's professional ethics, qualifications and skill that may bear on the ability to provide good patient care in the Hospital;

viii. Current physical and electronic addresses and telephone numbers of home and offices;

ix. Current disclosure of potential conflicts of interest.

x. Information on any criminal record, including arrests or convictions of misdemeanor or felony crimes;

xi. Current good quality physical or digital photograph.

b. Results from query of National Practitioner's Data Bank and Office of Inspector General or other queries as appropriate.

c. Evidence that the practitioner/professional has had a role in the care of WNH patients or organizational operations during the current term of membership.

d. Other relevant information including, but not limited to risk management, quality improvement and utilization profile data.

8. *Board Action*

The Board of Trustees acts on the MEC's recommendations regarding reappointments prior to the end of the provider's two year term.

a. Where non-reappointment or a change in clinical privileges is recommended by the MEC, the reason for such a recommendation shall be clearly documented;

b. Members shall be notified in writing within ten (10) days by the CEO, including any practitioner/professional whose reappointment is refused by the Board.

c. If reappointment or specific privileges are denied by the Board, a practitioner/professional may reapply after six months from the Board's denial, or seek hearing and review as stated under Article VI.

9. *Practitioners/Allied Health Professionals Under Contract*

Practitioners/professionals providing limited professional medical services to the Hospital *may not* be required to apply for or maintain Medical Staff membership. All of the following criteria must be met for this exception.

a. Services are generally limited in scope and scale, conducted off-site and are not considered direct patient care (e.g. teleradiology).

b. A formal contract exists between the legal organization and the Hospital and/or member(s) of the Medical Staff. A copy of the contract and all subsequent revisions is provided to the Hospital.

c. The minimum professional information about each practitioner/professional is on file (same as required for temporary privileges).

d. The Hospital and Medical Staff monitors performance of contract practitioner/professionals and reports problems to the other in a timely fashion.

e. The WNH MEC approves any new services under this provision and routinely approves continued clinical service of the contractor.

Revised 6/2021

WILLIAM NEWTON HOSPITAL
Medical Staff Bylaws

Article III
Categories of the Medical Staff

1. *General*

Each Medical Staff appointee is assigned to a staff category by the Medical Executive Committee (MEC) and approved by the Board of Trustees. In the event that the MEC believes any member of the Medical Staff no longer meets the qualifications of membership or staff category, the member shall be given 30 days to submit proof of qualifications or request change of membership category.

a. The Medical Staff shall be divided into Active, Courtesy, Consulting, Honorary and Allied Health Professional categories.

b. Regardless of staff category, all Active and Courtesy members having clinical privileges or Consulting physicians who perform procedures at WNH must:

i. Have offices and homes sufficiently close to the Hospital to provide timely care to their patients, or make arrangements with qualified members for appropriate and timely care. Any such arrangements must be consensual and clearly communicated to the covering member and the appropriate Hospital staff;

ii. Participate in the monitoring and evaluation activities of the Hospital and Medical Staff;

iii. Respond to reasonable requests to perform necessary Medical Staff functions as may be required;

iv. Complete patient medical records in timely fashion, as defined by regulations governing medical records in Kansas and in the Medical Staff Rules and Regulations;

v. Follow Medical Staff and department bylaws, rules, regulations, policies and procedural guidelines;

vi. Cooperate with Risk Management, Performance Improvement, Corporate Compliance and other programs of the Hospital.

vii. Apply for reappointment and privileges bi-annually

viii. Abide by the applicable scope of practice, guiding principles and codes of ethics of the relevant licensing agencies and professional associations, unless these conflict with those of the Hospital.

2. *Active Medical Staff*

The Active Staff shall consist of appointees who:

a. Meet the general qualifications for membership set forth in Article II of these Bylaws;

b. Regularly admit patients to the Hospital *or* spend a substantial portion of their professional time supporting the clinical activities of the Hospital;

c. Regularly are involved in Medical Staff functions, and have responsibilities as determined by these Bylaws, the MEC or the Chief of Staff, including active participation on committees or other service assignments and regular attendance at general meetings of the Medical Staff;

d. Have approved clinical privileges in the Hospital.

Prerogatives of the Active Medical Staff

Except as otherwise provided, an Active Staff member shall be entitled to:

a. Admit patients and exercise such clinical privileges as granted;

b. Attend and vote at general Medical Staff meetings;

c. Hold office on the Medical Staff;

d. Attend, participate and vote on Medical Staff committees;

e. Upon reaching age 65, Active Staff members may be excused, if requested in writing and approved by the MEC, from serving on standing committees of the Medical Staff.

3. *Courtesy Medical Staff*

a. May admit no more than 10 patients per year in the same manner as an Active Staff Member and may exercise such Clinical Privileges as are granted to him or her;

b. If a member of Courtesy Staff becomes aware that he or she will admit more than ten (10) patients per year, he or she shall make immediate application for membership on the Active Staff;

c. May not vote at Medical Staff meetings or hold office in the Medical Staff;

d. May serve on Medical Staff committees with vote, but shall not be eligible to serve on the MEC;

e. Are not required to attend Medical Staff meetings.

4. *Consulting Medical Staff*

The Consulting Staff shall consist of practitioners who do not meet the general qualifications for Active or Courtesy Staff membership.

Members of the Consulting Staff:

a. Shall be appointed to a specific Medical Staff service;

b. Are not eligible to vote at general Medical Staff meetings or hold office;

c. May attend general meetings of the Medical Staff and serve on Medical Staff committees;

d. Must refer all patients for admission to Active or Courtesy Medical Staff members

5. *Honorary Medical Staff*

The Honorary Staff shall consist of former members who have retired from healthcare after long-standing service to the Hospital and who have made exceptional contributions that benefit the Hospital, the provision of patient care or the health of the community.

Members of the Honorary Staff:

a. Are not eligible to admit patients, obtain clinical privileges, hold office, vote or serve on standing Medical Staff committees;

b. May attend general meetings of the Medical Staff and education opportunities;

c. Shall have no assigned obligations, but must maintain honorable reputations.

6. *Allied Health Professionals*

a. For the purpose of these Bylaws the Allied Health Professional staff includes, but is not necessarily limited to: appropriately licensed, registered or certified clinical psychologists, physician assistants, nurse anesthetists, nurse practitioners or advanced practice practitioners, nurse midwives, optometrists, and dietitians with ordering privileges.

b. Allied Health Professionals render services to Hospital patients under the following conditions:

i. Each is duly licensed, certified, or registered, as may be required by applicable State law <u>and</u> these Bylaws; and, when not employed by WNH, provide evidence of relevant liability insurance coverage;

ii. Each pursues only those specific clinical activities for which they are qualified;

iii. Each must be granted privileges by the Board of Trustees with recommendations from the applicable chief of service and the Executive Committee;

iv. Allied Health Professionals may admit patients only when specifically authorized by the Medical Staff and Board of Trustees, except as expressly provided below:

(a) An Allied Health Professional who is licensed as an independent certified nurse midwife ("CNM-I") may admit obstetrics patients without the specific authorization of the Medical Staff or Board of Trustees when such patient admissions are within the scope of the CNM-I's license and qualifications and are otherwise permitted under State law; and

(b) An Allied Health Professional who is a physician assistant ("PA") or advanced practice registered nurse ("APRN") who performs services at the Hospital on behalf of a physician practice group or other physician organization that consists of one or more physician members of the WNH Medical Staff, may, after appropriate consultation with such PA or APRN's supervising physician, admit patients on behalf of such physician group or organization without the specific authorization of the Medical Staff or Board of Trustees when such admissions are within the scope of the PA or APRN's license and qualifications and are otherwise permitted under State law.

v. Depending on relevant law and the specific privileges granted, Allied Health Professionals who are practicing independently retain responsibility for their own acts;

vi. When Allied Health Professionals are not acting independently, and are under the supervision of, whether or not in the employ of, a member of the WNH Medical Staff, then that member is responsible for the acts of the Allied Health Professional;

vii. Allied Health Professionals are assigned to the clinical service or department relevant to their areas of clinical practice. Each is responsible to the appropriate chief of service, medical director and the technical director of the service or department.

7. Telemedicine Staff

a. Credentialing and privileging of providers for telemedicine service3s may be fulfilled by written agreement with a contracted hospital or telemedicine entity in which the provider has been fully privileged and credentialed in accordance with Medical Staff Bylaws and policies.

b. The Telemedicine Staff is composed of practitioners who solely participate in the care of patients through telemedicine.

c. According to 42CFR 482.22(1)(3) The Governing Body of Hospitals and CAH's whose patients are receiving telemedicine services may choose to have its Medical Staff rely on the privileging and credentialing decisions made by a distant site hospital or distant-site

telemedicine entity when granting privileges to practitioners providing telemedicine services, provided there is a written agreement that complies with all specified requirements.

Revised 12/2020
Revised 6/2021

Article IV
Clinical Privileges

1. *Obligations*

Practitioners/professionals exercise only those clinical privileges which are specifically requested by the applicant, recommended by the Medical Executive Committee (MEC) and granted by the Board of Trustees. Obligations accompany the receipt of clinical privileges regardless of membership category or status. General clinical obligations include:

a. Be subject to the rules and regulations of all clinical departments in which privileges are held, and to the authority of the applicable chiefs-of-service or committee chair persons;

b. Complete patient medical records as specified in Medical Staff Bylaws, Rules and Regulations and Hospital policy;

c. Participate in reviews of quality, efficiency, appropriateness, and accessibility of patient care;

d. Cooperate with procedures for renewing clinical privileges at the time of reappointment;

e. Provide or arrange for continuous medical care for the practitioner's patients in William Newton Hospital, and obtain consultation when necessary for patient safety or when required by the Bylaws, Rules and Regulations;

f. Comply with all federal and state regulations and Hospital requirements regarding the care and transfer of patients.

2. *Proof of Qualification and Competency*

The Hospital provides each applicant, as part of the initial application procedure and at membership renewal, an opportunity to request those specific clinical privileges which the practitioner wishes to exercise. It is the applicant's responsibility to provide objective evidence of qualifications and competency in these clinical areas. A request for a modification of clinical privileges may be made at any time, but such request must be supported by documentation of training and/or experience.

3. *Periodic Renewal of Clinical Privileges*

At reappointment time, requests for specific clinical privileges must be updated by the staff member and acted on by the MEC and the Board. The basis for determination of new or continued clinical privileges may include observed clinical performance, documented results of risk management, quality improvement and utilization review activities, or all of the above.

4. *Evaluation of Qualifications*

Medical Staff recommendations and subsequent Board actions are based on information about each individual applicant's evidence of training, experience, continuing education and current demonstrated clinical competence and judgment as documented and verified in each member's credential file.

5. *Dentists – Podiatrists*

a. Regardless of staff category or department assignment of dentists and podiatrists, surgical procedures performed by them are under the overall supervision of the Chief of Surgery. Dentists or podiatrists may write orders within the scope of their licenses to practice and within the scope of Medical Staff Bylaws, Rules and Regulations.

b. Dentists and podiatrist appointees of the Medical Staff may only admit patients for diagnosis and treatment of conditions within the scope of their licensure and privileges granted by the Board.

c.

The medical history and physical examination of the patient admitted or undergoing surgery by a podiatrist are the responsibility of the podiatrist along with the consulting physician if the patient is not medically stable or has a history of instability, anesthesia beyond local anesthesia is planned, or care is beyond the scope of podiatric privileges.

The medical history and physical examination of the patient admitted or undergoing surgery by a dentist as well as the responsibility for the treatment of specific concomitant medical disease throughout the period of hospitalization are the responsibility of a consulting practitioner, except that qualified oral and maxillofacial surgeons may do their own history and physicals.

6. *Mid Level Practitioners (MLP) or Advanced Practice Practitioners (APP)*

a. Specific descriptions of clinical privileges for allied health professionals/midlevel practitioners are described in the Rules and Regulations section of these Bylaws.

7. *Provisional Privileges*

a. All initial appointments to any category of the Medical Staff shall be provisional for six months. Provisional membership may not exceed one year.

b. Each initial appointee shall be assigned to a service for observation by the chief of service who will recommend eligibility for continued Medical Staff membership and privileges. The provisional designation is removed by the Board upon receiving from the chief of service and the MEC reasonable assurance that the member is capable of and willing to fulfill the responsibilities of appointment in the chosen area of clinical practice. The provisional period may be extended for up to an additional six months for good cause on the recommendation of the MEC with approval by the Board.

8. *Temporary Privileges*

a. General Requirements:

i. During the time any temporary privileges are in effect, the practitioner/professional is subject to the supervision of the chief of service in the service assigned.
ii. Temporary privileges may be granted to current members or non-members.
iii. Proof of current licensure and relevant malpractice insurance is required along with evidence of training and/or experience and clinical competence in the privileges requested.
iv. For non-members, Administration will query the National Practitioner Data Bank at a minimum and review other resources as needed.
v. Temporary privileges may be granted jointly by the Chief of Staff and Chief Executive Officer or their delegates.
vi. Temporary privileges may be granted for up to 35 days and extended an additional 35 days with good cause. Temporary privileges beyond 70 days require the recommendation of the MEC and approval by the Board.
vii. Notice will be sent to all departments of privileges granted and temporary status.

b. Patient Specific Temporary Privileges: Temporary admitting and clinical privileges to care for a specific patient and limited to the duration of the patient's stay in the Hospital may be granted to members and non-members.

c. Locum Tenens: Admitting and clinical privileges may be granted to non-member practitioners providing temporary coverage for a member.

d. During Process of an Application: Temporary privileges may be granted to an applicant seeking permanent membership and/or privileges before action on an application is final.

e. Individuals in Training: Individuals in training, such as medical and anesthesia students, may participate in care of patients only under the supervision of an assigned member(s) of the Medical Staff. A contractual arrangement with the school or written approval of the Chief Executive Officer and signing of a confidentiality statement by the trainee is required. Approval of the Chief of Service is required for a non-physician member to supervise a medical student.

9. *Emergency Privileges*

a. In cases of an emergency, any staff member, to the degree permitted by license and regardless of staff status, department assignment or clinical privilege delineation, shall assist in the care of the patient. For the purpose of this section, "emergency" refers to a condition in which serious or permanent harm might result to a patient, or in which the life of the patient is in immediate danger if there is any delay in administering treatment.

b. During a disaster declared according to the WNH Disaster Management Plan, non-member licensed independent practitioners and allied health professionals may be granted temporary privileges within their scopes of practice until care can be safely transferred to a member of the Medical Staff. Minimum verification shall include copies of license, malpractice insurance and DEA number.

10. *Special Privileges to Retrieve Human Tissue*

Special privileges may be granted upon application by physician, surgical teams and support personnel for the purpose of retrieving human tissue of organs for transplantation, research or other medical endeavors. Such application for special privileges shall be in accordance with the Bylaws, Rules and Regulations of the Medical Staff and any existing protocols relating to such matters.

11. *Medico-Administrative Positions*

Physicians employed by the Hospital whose duties include both administrative and clinical activities must be members of the Medical Staff, and must obtain clinical privileges in the same manner as any other Medical Staff member. The contract of the Hospital employed physician who has administrative and/or clinical duties should clearly define the relationship between termination of employment by the Hospital through the individual's contract, and reduction or termination of clinical privileges through the provisions of these Bylaws.

Revised 11/2019
Revised 6/2021

Article V
Investigations, Corrective Action and Risk Management

1. *Reporting Requirements.*

   a. Staff Obligation: Every member of the Medical Staff shall be required to report any direct knowledge that any other member of the Medical Staff has committed an act that is or may be below the applicable standard of care in this Hospital, or that is or may be grounds for disciplinary action by a licensing agency such as the Kansas Board of Healing Arts. In addition, each member of the Medical Staff shall be obligated to report any direct knowledge that any other person who is directly involved in providing healthcare services to patients in the Hospital has committed an act that is or may be below the applicable standard of care within the Hospital.

   b. Method of Reporting: Any report regarding possible sub-standard patient care shall be forwarded to the Risk Manager pursuant to the Risk Management Plan. This does not preclude initially contacting a chief of service, the Chief of Staff or the Chief Executive Officer (CEO) to report any concerns that may require immediate action.

   c. Risk Manager: The Risk Manager shall direct patient care incidents to the appropriate Medical Staff committee as outlined in the Hospital Risk Management Plan, which may be amended from time to time.

2. *Grounds for Corrective Action.*

   Corrective action against a Medical Staff member may be initiated whenever the member engages in or exhibits actions, or failure to act, statements, demeanor or conduct, either within or outside the Hospital, that is, or is reasonably likely to be:

   a. Contrary to the Medical Staff Bylaws, Rules and Regulations, the Hospital's bylaws, policies or procedures, or the Hospital's Corporate Compliance Plan;

   b. Detrimental to patient safety or to the quality of patient care in the Hospital;

   c. Disruptive to Hospital operations;

   d. Damaging to the Medical Staff's or the Hospital's reputation;

   e. Below the applicable standard of care;

   f. In violation of any law or regulation relating to federal or state reimbursement programs;

   g. Constitutes unprofessional conduct as defined in Kansas Administrative Regulation 100-55-5.

3. *Authority*

The following may request that corrective action be considered: any officer of the Medical Staff; a chief of service in which the staff member exercises privileges; any standing committee or subcommittee of the Medical Staff or a chairperson thereof; the (CEO); the Risk Manager; the Board of Trustees.

4. *Discretionary Interview and Resolution Prior to Corrective Action*

Prior to requesting corrective action against a staff member, the authorized party considering such action may, but is not obligated to, afford the staff member an informal interview at which the circumstances are discussed and the staff member is permitted to present relevant information on his or her own behalf. This interview is not a procedural right of the staff member and need not be conducted according to the procedural rules provided in Article VI of these Bylaws. Said party shall prepare a dated, written record of the interview indicating the type of problem, what was discussed with the staff member, and any resulting resolution. This written report shall be retained in the staff member's confidential Risk Management peer review file.

5. *Initiation, Requests, Notices*

All requests for corrective action shall be submitted to the Medical Executive Committee (MEC) in writing, and shall be supported by a written statement of the specific activities or conduct that constitutes the grounds for the request. The Chief of Staff shall promptly notify the (CEO) of such requests, and provide a copy of said statement to the same.

6. *Informal Interview*

Upon receipt of a request for corrective action, the MEC or its designee may, at the Committee's option, conduct an informal interview with the staff member against who corrective action has been requested. At such interview, the staff member will be informed of the concerns against him or her and will be invited to discuss, explain, or refute them. This interview shall not constitute an "investigation" or a "hearing", will be preliminary in nature, and will not be subject to any of the procedural rules provided in Article VI of these Bylaws. A summary of interview shall be included with the report from the MEC to the Board of Trustees and shall be placed in the staff member's confidential Risk Management peer review file.

7. *Investigation.*

Upon receipt of the request for corrective action, and following any discretionary or informal interview with the affected staff member as described in Sections 4 and 6 of this Article, the MEC shall either act on the request or direct, by written resolution, that a formal investigation concerning the grounds for the corrective action requested be undertaken. The MEC shall give the staff member written notice within ten (10) days, either personally or by certified mail, describing the specific conduct in question and the reason for the investigation. The MEC may conduct such investigation, which may include case review, or may assign the task to a medical staff officer, a chief of service, a standing committee, an individual or a group who is not affiliated with the Hospital, or any other Medical Staff component. This investigation process is not a "hearing" as that term is used in Article VI and shall not entitle the staff member to the procedural rights provided in said Article VI of these Bylaws. The investigative process may

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

8. *Medical Executive Committee (MEC) Action*

As soon as practicable after the conclusion of the investigative process, if any, the MEC shall act upon the request for corrective action, assign a risk management level if appropriate, and take action. Actions may include, without limitation, the following:

a. Rejection of the request for corrective action;

b. A letter containing suggestions, verbal warning and/or reprimand;

c. Education and/or training;

d. Medical or psychiatric treatment or referral of the staff member to the Kansas Medical Advisory Program or similar impaired provider program;

e. A probationary period with retrospective review of cases and/or other review of professional behavior, but without requirement of prior or concurrent consultation or direct supervision;

f. A requirement of prior or concurrent consultation or direct supervision;

g. A limitation of the right to admit patients;

h. Reduction, suspension or revocation of all or any part of the staff member's clinical privileges; or

i. Suspension or revocation of the staff member's Medical Staff membership.

9. *Effect of Medical Executive Committee (MEC) Action*

a. When the MEC's recommendation is deemed adverse (as defined in Article VI of these Bylaws) to the staff member, the (CEO) shall within five days so inform the staff member

by Special Notice, and he or she shall be entitled, upon timely and proper request, to the procedural rights contained in Article VI of these Bylaws.

b. When the MEC's recommendation for action is not adverse to the staff member, the (CEO) may, at his discretion, report the same to the Board of Trustees. The Board of Trustees may adopt or reject any portion of the MEC's recommendation or refer the recommendation back to the MEC for additional consideration, but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation must be made. If the Board's action is not adverse, the action shall be effective as its final decision. If the Board of Trustees decision is adverse to the staff member, the Board shall, within five days, notify the staff member by Special Notice, and he or she shall be entitled to the procedural rights provided in Article VI of these Bylaws.

c. If the MEC fails to act in processing and recommending action on a request for corrective action within an appropriate time as determined by the Board, then the Board may, after informing the MEC of its intent, make its own determination using the same type of criteria considered by the MEC. If the Board's decision is adverse to the staff member, the Board shall within five days so inform the staff member by Special Notice, and he or she shall then be entitled to the procedural rights provided in Article VI of these Bylaws.

10. *Other Action*

The commencement of corrective action procedures against a staff member shall not preclude the summary suspension of all or any portion of any of said staff member's clinical privileges in accordance with the procedure set forth in Section 11 of this Article.

11. *Summary Suspension*

a. Whenever a staff member's conduct is of such a nature as to require immediate action to protect the life of any patient or to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee or other person present in the Hospital, or to preserve the continued effective operation of the Hospital, any of the following has the authority to suspend summarily the Medical Staff membership or all or any portion of the clinical privileges, of such staff member:

i The Chief of Staff;

ii. The applicable chief of service;

iii. The (CEO), after conferring when possible with either the Chief of Staff or other officer of the Medical Staff;

iv. The MEC; or

v. The Board of Trustees.

b. A summary suspension is effective immediately upon oral notice to the staff member. The person or group imposing the suspension shall immediately inform the (CEO) of the suspension, and the (CEO) shall also within five days give Special Notice thereof to the staff member. The applicable chief of service shall assign a suspended staff member's

patients then in the Hospital to another staff member, considering the wishes of the patients, where feasible, in selecting a substitute staff member.

c. As soon as possible, but in no event later than 14 days after a summary suspension is imposed, the MEC shall convene to review and consider the need, if any, for a professional review action. Such a meeting of the MEC shall in no way be considered a "hearing" as contemplated in Article VI of these Bylaws (even if the staff member involved attends the meeting) and no procedural requirements shall apply. The MEC may recommend modification, continuation or termination of the terms of the summary suspension.

d. The effect of the MEC's action shall be as set forth in Section 9 of this Article. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision of the Board of Trustees.

12. *Automatic Revocation, Restriction or Suspension*

a. Occurrences Affecting Licensure:

i. Revocation:
When a staff member's license to practice in Kansas is revoked, his or her Medical Staff membership and clinical privileges shall be immediately and automatically revoked as of the date of license revocation.

ii. Restriction:
When a staff member's license to practice in Kansas is limited or restricted, those clinical privileges that he or she has been granted that are within the scope of the limitation or restriction shall be similarly automatically limited or restricted as of the date of license limitation or restriction.

iii. Suspension:
When a staff member's license to practice in Kansas is suspended, his or her Medical Staff membership and clinical privileges are automatically suspended effective upon and for the term of the licensure suspension.

b. Occurrences Affecting Controlled Substances Regulation:

i. Revocation:
When a staff member's Drug Enforcement Administration (DEA) or other controlled substances number is summarily revoked his or her right to prescribe medications covered by the number is similarly suspended or restricted during the term of the suspension or restriction.

ii. Suspension or Restriction:
When a staff's member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly suspended or restricted during the term of the suspension or restriction.

c. Medical Records Completion:
See Section 3, Health Information, Medical Staff Rules and Regulations, all of which is incorporated herein by reference.

d. Professional Liability Insurance:
Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer shall result in immediate and automatic suspension of staff member's Medical Staff membership and clinical privileges until such time as a certificate of appropriate insurance coverage is furnished.

e. Exclusion from State or Federal Health Care Reimbursement Programs:
Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, the staff member's privileges to admit or treat affected patients shall be immediately and automatically suspended until such time as the exclusion, debarment or prohibition is lifted.

f. Procedural Rights and Additional Corrective Action:
No staff member shall be entitled to the procedural rights set forth in Article VI of these Bylaws as a result of the sanctions automatically imposed pursuant to the preceding Subsections (a) through (e) hereof. Any of the persons entitled to initiate corrective actions under Section 3 of this Article may, however, initiate such action on the basis of any of the occurrences specified in Subsections (a) through (e), and if as a result thereof an adverse recommendation or decision is made which exceeds the scope of the sanctions automatically imposed under said Subsections (a) through (e), then the staff member shall be entitled to the same procedural rights to which he or she would be entitled under Section 9 of this Article, but only with respect to the additional sanctions recommended or imposed.

13. *Reports to Board of Healing Arts or Other Applicable Board*

a. Reports Regarding Privileges:
The (CEO) shall inform the relevant licensing board whenever the clinical privileges of any staff member are terminated, suspended, restricted, or surrendered, voluntarily or otherwise, for reasons relating to such staff member's professional competence. Such reports shall be submitted when any termination, suspension or restriction is final. Any of the above limitations that exceed 30 days shall also be reported to the National Practitioners Data Bank. Any other information required to be reported with regard to any staff member to the Kansas Board of Healing Arts or the Kansas Dental Board or other applicable board by the Health Care Quality Improvement Act of 1986 shall be reported in the time and manner specified by the said Act and applicable state and federal regulations and guidelines.

b. Reports Regarding Standard of Care:
Any finding by the MEC that a staff member has acted below the applicable standard of care or has committed an act that is grounds of disciplinary action pursuant to K.S.A. 65-2836 shall be reported to the Kansas Board of Healing Arts, Kansas Dental Board or other relevant board when required by state or federal regulation and as outlined in the Hospital Risk Management Plan.

14. *Risk Management*

The Hospital hereby charges the MEC with responsibility for final investigation and determination of applicable standards of care for the Medical Staff, except where otherwise ~~as~~ delineated in the Hospital Risk Management Plan, as may be amended from time to time. All proceedings, findings and reports of this peer review process by this committee or any committee authorized to conduct peer review are confidential and shall not be subject to discovery or use in any judicial or administrative proceeding, except as otherwise provided by statute. The above statements are consistent with State laws K.S.A. 65-4915, K.S.A 65-4921 et seq., K.S.A. 65-4923, K.S.A. 65-4924 and K.S.A. 65-4925.

Revised 6/2021

Article VI
Hearing and Appellate Review

1. *Initiating Recommendations or Actions*

The following recommendations or actions shall, if deemed adverse pursuant to Section 2 of this article, entitle the practitioner/professional thereby affected to a hearing:

a. Denial of initial staff appointment;

b. Denial of reappointment;

c. Suspension of staff membership;

d. Denial of requested change in staff category;

e. Reduction in staff category;

f. Limitation of admitting privileges;

g. Limitation of clinical privileges for more than 30 days.

2. *When Deemed Adverse*

A recommendation or action listed in Section 1 herein shall be deemed adverse only when it has been:

a. Taken by the Board of Trustees in accordance with the recommendation of the Medical Executive Committee (MEC); or

b. Taken by the Board contrary to a favorable recommendation by the (MEC); or

c. Taken by the Board on its own initiative without benefit of a prior recommendation by the (MEC).

The issuance of a letter of admonition, censure, reprimand or warning, extension of provisional status, or the denial, termination or reduction of temporary privileges shall not be deemed adverse actions. Any automatic suspension under Article V, Section 12 of the Bylaws shall not be considered adverse action that entitles the practitioner/professional to a hearing. The cancellation, termination or non renewal of a member's employment contract or contract for professional services shall not be considered adverse action here under.

3. *Notice of Adverse Recommendation or Action*
A practitioner/professional against whom an adverse action has been taken or recommended pursuant to Article VI, Section 2 shall be given Special Notice within five working days in person or by certified mail. The notice shall describe the action or recommendation and the reasons for it. The notice shall also state that the practitioner/professional has the right to request

a hearing within the time limit specified in Section 4 hereof and shall contain a summary of the practitioner/professional rights in such hearing.

4. *Request for Hearing*

A practitioner/professional shall have 30 days after receipt of notice pursuant to Section 3 herein to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer (CEO) either in person or by certified mail.

5. *Waiver by Failure to Request a Hearing*

A Medical Staff member who fails to request a hearing within the time and in the manner specified in Section 4 herein waives any right to such hearing and to any appellate review to which might otherwise have been entitled. Such waiver shall constitute acceptance of the adverse action or recommendation.

6. *Notice of Time and Place for Hearing*

Upon receipt of a timely request for hearing, the CEO shall deliver such request to the Chief of Staff or to the Board of Trustees, depending on whose recommendation or action prompted the request for hearing. Within 10 days after receipt of such request, the Chief of Staff or the Chairman of the Board shall schedule and arrange for a hearing. At least 30 days prior to the hearing, the CEO shall send Special Notice to the practitioner/professional of the time, place, and date of the hearing. The notice of the hearing provided to the practitioner/professional shall include a list of witnesses, if any, expected to testify at the hearing in support of the proposed action.

7. *Conduct of Hearing*

If the adverse action that is the subject of the hearing was recommended by the MEC, the hearing shall be held before a hearing officer or hearing committee, as determined by the Chief of Staff. If the adverse action was taken by the Board, the chairman of the Board shall determine whether the hearing shall be held before a hearing officer or a hearing committee. The hearing officer shall be appointed by either the Chief of Staff or the Chairman of the Board pursuant to Section 8 herein. A hearing committee shall be appointed by either the Chief of Staff or the Chairman of the Board pursuant to Section 9 herein.

8. *Appointment of Hearing Officer*

The hearing officer may be a physician, dentist, attorney, or other individual qualified to conduct the hearing. The hearing officer is not required to be a member of the Medical Staff. To the extent possible, the hearing officer should not be in direct economic competition with the practitioner/professional involved in a hearing. In no event shall the hearing officer be of the same medical subspecialty as the effected staff member.

9. *Appointment of Hearing Committee*

a. By Chief of Staff

A hearing committee appointed by the Chief of Staff shall consist of at least three members, one of whom shall be designated as Chairman by the Chief of Staff. All members of the hearing committee shall be practitioners, unless the person in question is an allied health professional, in which case the Chief of Staff may include an appropriate allied health professional on the hearing committee. Hearing committee members are not required to be members of the Medical Staff.

b. By Chairman of the Board
A hearing committee appointed by the Chairman of the Board shall consist of at least three persons. One of the members shall be designated as chairman by the Chairman of the Board. Subject to the provisions of Section 9c, herein at least one member of the committee shall be a member of the Medical Staff when possible. Other members of the committee are not required to be members of the Medical Staff, and if no member of the Medical Staff is available because of the provisions of Section 9c herein, no committee member shall be required to be a member of the Medical Staff.

c. Service on Hearing Committee

A Medical Staff or Board member shall not be disqualified from serving on a hearing committee merely because the member participated in investigating the underlying matter at issue or because the member has heard of the case. However, to the extent possible no member of a hearing committee should be in direct economic competition with the member involved in the hearing. All members of a hearing committee shall be required to objectively consider all evidence and decide the case in good faith.

10. *Forfeiture of Hearing*

A practitioner/professional, who requests a hearing pursuant to this Article but fails to appear at the hearing without good cause, as determined by the hearing committee or hearing officer, shall forfeit the individual's rights to such hearing and to any appellate review to which might otherwise have been entitled.

11. *Presiding Officer*

An individual qualified to conduct hearings may be designated as the presiding officer for a hearing to be heard by the hearing committee. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence. Such individual need not be a member of the hearing committee.

12. *Representation*

The practitioner/professional who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing, by a member of their professional society, or by an attorney. The Medical Staff or the Board may appoint a member of the Medical Staff or an attorney to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses.

13. *Rights of Parties*

During a hearing, each of the parties shall have the right to:

a. Call, examine and cross-examine witnesses;

b. Introduce any relevant evidence, including exhibits;

c. Question any witnesses on any matter relevant to the issues;

d. Impeach any witness;

e. Rebut any evidence;

f. Make a record of the hearing by use of a court reporter or an electronic recording unit at the party's expense, and

g. Submit an oral or written statement at the close of the hearing.

In the event that the practitioner/professional who requested the hearing does not testify in own behalf, the practitioner/professional may still be called by the Board or Medical Staff and examined as if under cross-examination.

14. *Procedure and Evidence*

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issues of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer shall order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents.

15. *Information Pertinent to Hearing*

In reaching a decision, the hearing committee or hearing officer shall be entitled to consider any pertinent material contained on file in the Hospital, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

16. *Burden of Proof*

When a hearing relates to Section 1, paragraphs *a* or *d* hereof, the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any factual basis or that such basis or the conclusions drawn therefrom are arbitrary, unreasonable, or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the practitioner shall thereafter be responsible for supporting any challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusions drawn therefrom are arbitrary, unreasonable, or capricious.

17. *Postponement*

Requests for postponement of a hearing may be granted by the chairman of the hearing committee or the hearing officer upon a showing of a good cause.

18. *Recesses and Adjournment*

The hearing committee or hearing officer may recess the hearing and reconvene it, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

19. *Report*

Within 10 calendar days after the hearing is closed, the hearing committee or hearing officer shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing. The report shall include a statement of the basis for its recommendations. A copy of the report shall be provided to the practitioner/professional involved in the hearing.

20. *Action on Report*

Within 20 calendar days after receipt of the report, the MEC or the Board of Trustees, as the case may be, shall reconsider the same and affirm, modify or reverse its recommendation or action in the matter. The decision shall be in writing and shall include a statement as to its basis. The decision shall be transmitted, together with the hearing record, the report of the hearing committee or hearing officer and all other documentation considered, to the CEO.

21. *Notice and Effect of Result*

a. Notice

The CEO shall send within five days a copy of the decision to the practitioner/professional, Chief of Staff, and Board of Trustees.

b. Effect of Favorable Result

i. Adopted by the Board: If the Board's decision pursuant to Section 20 hereof is favorable to the practitioner/professional, such result shall become the final decision of the Board and the matter shall be considered closed.

ii. Adopted by the MEC: If the MEC's decision pursuant to Section 20 hereof is favorable to the practitioner/professional, the CEO shall within five days forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's decision in whole or in part, or by referring the matter back to the MEC for further consideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The CEO shall deliver Special Notice within five days to the practitioner/professional informing of each action taken pursuant to this Section 21*b*(2) and providing copies of all actions, referrals or recommendations. A favorable determination shall become the final decision of the Board, and the matter shall be considered closed. If the Board's action is adverse as defined in Article VII, Section 1, the notice shall inform the practitioner/professional of the right to request an appellate review by the Board as provided in Section 22 hereof.

c. Effect of Adverse Result

If the decision of the MEC or of the Board of Trustees continues to be adverse to the practitioner/professional, the notice required by Section 21*a* hereof shall inform the practitioner of this right to request an appellate review by the Board as provided in Section 22 hereof.

22. *Request for Appellate Review*

A practitioner/professional shall have 15 calendar days after receipt of a notice pursuant to Section 21*b*(ii) or 21*c* hereof to file a written request for an appellate review. Such request shall be delivered to the CEO, either in person or by certified mail, and may include a request for a copy, at the practitioner's/professional's cost, of the record of the hearing and all other material, favorable or unfavorable, that was considered in making the adverse decision.

23. *Waiver by Failure to Request Appellate Review*

A practitioner/professional who receives the requisite notice and fails to request an appellate review within the time and in the manner specified in Section 22 hereof waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 5 hereof.

24. *Notice of Time and Place for Appellate Review*

Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board. Within 15 days after receipt of such request, the Board shall schedule and arrange for an

appellate review which shall be not less than 30 days or more than 90 days from the date of receipt of the appellate review request. At least 20 days prior to the appellate review, the CEO shall deliver Special Notice to the practitioner/professional of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body upon request of the practitioner/professional.

25. *Appellate Review Body*

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of three or more members of the Board appointed by the Chairman of the Board. If a committee is appointed, one of its members shall be designated as chairman.

26. *Nature of Appellate Review Proceedings*

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee or hearing officer, the report, and all subsequent results and actions thereon. The appellate review body shall also consider any written statements submitted pursuant to Section 27 hereof and such other materials as may be presented and accepted under Sections 29 and 30 hereof.

27. *Written Statements*

The practitioner/professional seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which the practitioner/professional disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body through the CEO at least five days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the MEC or by the Board, and if submitted, the CEO shall provide a copy thereof to the practitioner/professional prior to the scheduled date of the appellate review, if possible.

28. *Presiding Officer*

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

29. *Oral Statement*

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.

30. *Consideration of New or Additional Matters*

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate

review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

31. *Recess and Adjournment*

The appellate review body may recess the review proceedings and reconvene the same, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed.

32. *Action Taken*

The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action or, in its sole discretion, may refer the matter back to the hearing committee or hearing officer for further review and recommendation to be returned to it within 30 days and in accordance with its instructions. Within 30 days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board as provided herein.

33. *Conclusion*

The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein shall have been completed or waived.

34. *Board Action as Final Decision*

Within 45 days after receipt of the appellate review body's recommendation, the Board shall render its final decision in the matter in writing and shall deliver Special Notice thereof to the practitioner/professional and to the Chief of the Medical Staff.

35. *Waiver*

If at any time after receipt of notice of an adverse recommendation, action or result, a practitioner/professional fails to make a required request or appearance or otherwise fails to comply with this Article, the practitioner/professional shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which the individual might otherwise have been entitled with respect to the matter involved.

36. *Number of Reviews*

Notwithstanding any other provisions of the Medical Staff Bylaws, no practitioner/professional shall be entitled as of right to more than one evidentiary hearing and one appellate review with respect to an adverse recommendation or action.

37. *Exhaustion of Remedies*

Any person seeking hearing or appellate review that this article applies to must exhaust the remedies afforded within it before resorting to any form of legal action.

Article VII
Officers

1. *Officers of the WNH Medical Staff*

Officers are the President (Chief of Staff), President-elect, Past President, and up to four (4) members of the Medical Staff elected at large. These officers serve as the Medical Executive Committee (MEC) of the Medical Staff. The MEC shall have a minimum of five members and a maximum of 7 members.

2. *Eligibility Requirements*

Only Active Staff members are eligible to be elected as officers and failure to meet the requirements of Active Staff membership during the term of office will result in automatic removal from office.

3. *Selection of Officer and Medical Executive Committee (MEC) Candidates*

In selecting its officers, the Medical Staff shall consider the responsibilities involved as well as the interests and skills required to best provide leadership, willingness to encourage Medical Staff participation in Hospital affairs and reasonable representation of clinical specialties and local group clinics.

4. *Nomination, Election and Terms of Office*

    a. Nominations: A slate of officer candidates is drafted by the President-elect in cooperation with Administration. Nominees are approved by the MEC and the slate presented to the Medical Staff at the election. Nominations may also be made from the floor at the time of the Medical Staff election.

    b. Election: Officers and other MEC members shall be elected at the Medical Staff meeting preceding the end of each Medical Staff Year. Only members of the Active Medical Staff in attendance shall be eligible to vote. A quorum is 50% of persons eligible to vote.

    c. Terms of Office: All officers serve a term of one (1) year and a maximum of six (6) consecutive years.

    d. Vacancies: Vacancies are filled by the MEC as soon as reasonably possible after the vacancy occurs, except that vacancy in the office of President is filled by the President-elect.

5. *Removal of Officers and Medical Executive Committee (MEC) Members*

Failure of an officer MEC member to maintain Active Staff status shall result in automatic removal from office. In addition, the Medical Staff may, by a two-thirds (2/3) majority of eligible members voting, remove any Medical Staff officer for failure to fulfill responsibilities, malfeasance in office, physical or mental infirmity to a degree that renders the member incapable

of fulfilling the duties of office, or conduct detrimental to the interests of the Medical Staff and/or Hospital. This action is subject to final approval by the Board.

6. *Duties of Officers*

a. President (Chief of Staff): The President shall serve as the Chief of the Medical Staff to:

i. Act in coordination and cooperation with the Chief Executive Officer (CEO) or designee in all matters of mutual concern within the Hospital;

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

iii. Serve as Chairman of the MEC;

iv. Serve as ex-officio member of all other Medical Staff committees;

v. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations;

vi. Appoint chiefs of service, medical directors, committee chairs and members to all standing, special, and multi-disciplinary committees except as otherwise provided;

vii. Serve on the Board of Trustees as a non-voting member, attend the Board of Trustees meetings, and present the views, policies, and needs of the Medical Staff.

viii. Interpret the policies of the Board to the Medical Staff, and report to the Board on performance and maintenance of quality and prudent patient care;

ix. Submit the Medical Staff recommendations to the Board on all matters relating to the appointment, reappointment, and clinical privileges of practitioners and specified allied health professionals.

x. Work with the Board and Administration to achieve and maintain regulatory and accreditation compliance.

xi. Participate in real disasters and drills by working cooperatively with the emergency room chief of service and Hospital disaster committee in coordinating Medical Staff activities.

xii. Assure that the Medical Staff is organized, well informed and documented, including:

- Provide for accurate and complete minutes of all Medical Staff meetings, including the MEC and other Medical Staff committees;
- Call special Medical Staff meetings as needed;
- Provide for a record of attendance at meetings;
- Attend to all correspondence on behalf of the Medical Staff;
- Make minutes and correspondence available to the Board;
- Provide for relevant educational activities for the Medical Staff.

b. President-elect: In the absence of the President, the President-elect shall assume the duties and the authority of the President. In addition, the President-elect shall:

i. Be a member of the MEC;

ii. Automatically succeed the President when the latter fails to serve for any reason prior to the end of the President's term;

iii. Perform such reasonable duties as may be assigned by the President and/or Bylaws;

d. Past President: In the absence of the President and President-elect, the Past President shall assume all duties of the President. In addition, the Past President shall:

i. Be a member of the MEC.

ii. Perform such reasonable duties as may be assigned by the President and/or Bylaws;

e. Members at Large:

i. Be members of the MEC.

ii. Perform such reasonable duties as may be assigned by the President and/or Bylaws;

f. Line of Authority: President (Chief of Staff); President-elect; Past President; Members at Large in order of appointment.

7. *Assistance with Duties*

The President and MEC may seek assistance from the Hospital with many of the duties listed above (e.g. communications, information gathering, minutes, etc.). However, the Medical Staff retains authority and responsibility for these duties.

Revised 6/2021
11/2021

Article VIII
Services

1. *Organization of Services*

There shall be services of medicine, surgery, obstetrics, anesthesia, emergency room, pathology/laboratory, pediatrics, cardiology and radiology. Each service shall be headed by a chief of service and shall function under the Chief of Staff and Medical Executive Committee (MEC).

2. *Qualifications, Selection and Tenure of Service Chiefs*

a. Each chief shall generally be a member of the Active Staff who is qualified by training, experience, and demonstrates ability for the position. When in the best interest of safe patient care, a member of the Consulting or Allied Health staff may be appointed and activities of that service are monitored by the appropriate standing committee.

b. Each chief shall be appointed by the Chief of Staff for a one year term and may be reappointed for successive terms.

c. Removal of a chief during the term of office may be initiated by a two-thirds majority vote of all Active Staff members of the service, but no such removal shall be effective unless and until it has been ratified by the MEC and by the Board of Trustees.

3. *Functions of Service Chiefs*

Each chief shall:

a. Be accountable for all professional and administrative activities within the service;

b. Participate in and make recommendations for quality control, assessment and improvement related to the service.

c. Provide oversight of the clinical and professional performance of all practitioners/professionals with clinical privileges in the service and report this information as requested to the MEC;

d. Investigate clinical concerns identified by members of the Medical Staff and Hospital staff and direct findings to the risk manager and/or appropriate committee;

e. Be responsible for enforcement of the Hospital Bylaws and the Medical Staff Bylaws, Rules, and Regulations within the service;

f. Be responsible for implementation within the service of actions taken by the MEC.

g. Transmit to the MEC the service's recommendations concerning the Medical Staff classification, appointment and reappointment, and the delineation of clinical privileges for all practitioners/professionals in the service;

h. Be responsible for the orientation, continuing education and research programs in the service;

i. Participate in every phase of administration of the service through assessment, recommendation and cooperation with Hospital departments in matters affecting patient care, including the number and qualifications of personnel, supplies, regulation compliance, policies and procedures, offsite services, space needs and integration of the service with other services.

j. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the service as may be required by the MEC, the Chief Executive Officer or the Board of Trustees.

4. *Clinical Privileges*

a. Each clinical service shall establish its own criteria consistent with the policies of the Medical Staff and of the Board of Trustees for the granting of clinical privileges in the service.

5. *Assignment to Services*

a. The MEC shall, after consideration of the recommendations of the clinical services, recommend initial service assignments for all Medical Staff members.

b. Medical Staff members shall have clinical privileges in one or more services in accordance with their education, training, experience and demonstrated competency. They shall be subject to all of the rules of such services and to the jurisdiction of each service chief involved.

Revised 6/2021

Article IX
Committees

1. *Committees*

The committees described in this Article shall be the standing committees for the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee (MEC) to perform special tasks. Committees may be combined as necessary to promote effective communication and efficiency. Unless otherwise specified, the chairman and members of Medical Staff committees shall be appointed prior to the year of service by the President-elect. If a member is unable to complete the term, the Chief of Staff may select a replacement if needed. Members may be removed from committees for good cause by approval of the MEC. Committees are responsible to the MEC, but are authorized to adopt policies and procedures if not inconsistent with these Bylaws, Rules and Regulations. Activities of the Medical Staff committees are confidential. Any committee conducting risk management/peer review may authorize external review as outlined in the Hospital Risk Management Plan.

2. *Committee Voting*

a. In the following committees, only physician members may vote: Executive, Health Information, Utilization Review, Quality Improvement/Risk Management, Surgical Review and Obstetrics. In all Medical Staff committees, only practitioner members may vote on matters of Medical Staff peer review.

b. In the following committees all designated members may vote: Infection Control and Home Health Advisory.

c. In the Pharmacy Committee all physician members and the Chief Pharmacist may vote.

d. In the Critical Care Committee the following members may vote: physicians plus Intensive Care, Emergency Room and Respiratory Services directors/supervisors.

e. A quorum exists in Medical Staff committee meetings when 50% of the Medical Staff members assigned to the committee are present. When a quorum does not exist, and the chairman determines that formal committee action should not be postponed, one physician member of the Medical Staff with appropriate qualifications may substitute with full voting privileges.

3. *Medical Executive Committee (MEC)*

a. Composition: The (MEC) shall consist of the officers of the Medical Staff. The Chief Executive Officer (CEO) and/or Assistant Administrators should attend meetings regularly and others when appropriate.

b. Term: MEC membership is limited to six consecutive years.

c. Meetings: The (MEC) will meet monthly and maintain permanent records of activities.

d. Duties: The duties of the MEC shall be:

i. To represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

ii. To coordinate the activities and general policies of the various services;

iii. To review the minutes of the various Medical Staff committees and act upon the recommendations of these committees and the services;

iv. To implement policies of the Medical Staff not otherwise the responsibility of the services or committees;

v. To be a liaison between the Medical Staff, CEO and Board of Trustees;

vi. To recommend action to the CEO on matters of a medico-administrative issues;

vii. To make recommendations on Hospital management matters (e.g., long range planning) to the Board of Trustees through the CEO or Chief of Staff;

viii. To fulfill the Medical Staff's accountability to the Board of Trustees for the medical care rendered to patients of the Hospital;

ix. To ensure that the Medical Staff is kept abreast of any accreditation, certification, governmental, financial or other challenges that may affect the provision of care at the Hospital;

x. To provide for the preparation of meeting programs and medical staff education, either directly or through delegation to a program committee or other suitable agent;

xi. To review the credentials of all applicants and to make recommendations to the Board of Trustees for Medical Staff membership, assignments to services and delineation of clinical privileges;

xii. To review periodically all information available regarding performance and clinical privileges, and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges;

xiii. To take all reasonable steps to ensure the professional and ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

xiv. To report on MEC actions and issues of interest at each general staff meeting;

xv. To serve as the final authority on matters of Medical Staff risk management as delineated in the Hospital Risk Management Plan and in accordance with state law;

xvi. To propose or review proposed amendments to the Medical Staff Bylaws, Rules and Regulations, consider the need for additional input from the Medical Staff, its components and/or Hospital leadership, and make recommendations for revision to the Board of Trustees.

4. *Health Information Committee*

a. Composition: The Health Information Committee shall consist of at least four representatives from the Medical Staff and one each from the nursing service and from Hospital management as well as the Health Information Management Director. Non-physicians shall serve ex-officio.

b. Meetings: The committee shall meet at least quarterly, shall maintain a permanent record of its proceedings and shall report to the MEC.

c. Duties: The duties of the Health Information Committee are:

i. To review medical records to determine that they are timely, legible, have clinical pertinence, and are adequate for use in quality assessment activities and, when necessary, as medico-legal documents. The committee has overall responsibility for assuring the highest standards for medical records;

ii. Ensure that the records reflect the diagnosis, condition and progress of the patient, including results of all tests and therapy given, and condition of the patient at discharge;

iii. Review summary information regarding the timely completion of all medical records and recommend actions for improvement;

iv. Be responsible for the format of the complete medical records, the paper and electronic forms used in the record, and the use of microfilming and electronic storage;

v. Review inpatient, ambulatory care, swing-bed and emergency room medical records. The medical records of the home health and rural health programs are generally reviewed in those programs.

5. *Utilization Review Committee*

a. Composition: The Utilization Review Committee shall be composed of at least four physicians appointed by the Chief of Staff in accordance with the Medical Staff Bylaws. These physicians will generally be chosen from the Active Medical Staff with broad representation of the scope of medical practice and shall have no direct financial interest in the Hospital. Employment, in and of itself, shall not be considered direct financial interest. Committee members may be reappointed. No physician committee member will review any case in which the physician has been professionally involved. The non-physician members of the committee shall be the CEO or delegate, the, Chief Nursing Officer and the Utilization Review Coordinator, all who shall all serve ex-officio.

b. Duties: This committee shall be responsible for conducting utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, length of stay, discharge practices, use of medical and hospital services, including inpatient and outpatient services and all related factors which may contribute to the effective utilization of the Hospital and physician services.

c. Extended Duration Evaluations: The committee shall evaluate the medical necessity of continued hospital services for patients where appropriate.

d. Meetings: The committee shall meet at least quarterly and records of its activities shall be kept. The minutes shall include a summary of the numbers and type of cases reviewed, specific findings and recommendations, corrective action or other information deemed pertinent by the committee. When indicated, educational programs will be presented to the Medical Staff on results of studies and recommendations for improvement. The Utilization Review Coordinator is responsible for initiating the utilization review.

f. Risk Management: The committee shall refer peer review issues that are beyond the scope of the UR Committee to the appropriate risk management committee.

6. *Quality Improvement/Risk Management*

a. Composition: The Quality Improvement/Risk Management Committee (QI/RM) shall consist of at least four members of the Medical Staff. Ex officio members may include the Risk Manager and representatives of Administration and other departments.

b. Duties: The QI/RM Committee is responsible for developing valid criteria that permit objective review of the quality of care provided to all patients. The results of patient care evaluation are reported to the Medical Staff, the CEO, and the Board of Trustees. The reports are confidential and included as a function of peer review. Relevant information is furnished to department directors as necessary. The committee shall also monitor quality improvement activities from all Hospital departments. The QI/RM Committee shall work in cooperation with the Utilization Review Committee in developing criteria and statistical information for continued stay review. They shall also recommend educational programs to be presented to the Medical Staff based on identified needs.

c. Meetings: The QI/RM Committee shall meet at least quarterly and minutes of the activities shall be kept and forwarded to the MEC.

d. Risk Management: The committee shall conduct peer review for Medical Staff risk management issues as delineated in the Hospital Risk Management Plan.

7. *Surgical Review Committee*

a. Composition: The Surgical Review Committee shall consist of at least four representatives from the Medical Staff who participate in surgical procedures. Ex officio members may include representatives of Administration, Anesthesia, Nursing Service, Health Information and the Operating Room Supervisor.

b. Duties: The duties of the Surgical Review Committee are:

i. Review of all surgical procedures performed in the Hospital. The committee may conduct special studies and shall report at least quarterly to the MEC;

ii. Review activities related to anesthesia;

iii. Review activities related to endoscopy;

iv. Review all Surgery Department elements related to assuring the safety of patients, practitioners and staff and make recommendations to the Hospital and/or MEC;

c. Surgical Case Review: The Surgical Review Committee shall develop clinical criteria and monitor surgical procedures on an ongoing basis to provide assurance of the quality of surgery performed, and;

i. Shall include cases in which a specimen (tissue or non-tissue) was removed, as well as those cases in which no specimen was removed;

ii. Shall include the indications for surgery and all cases in which there is a major discrepancy between the preoperative and postoperative (including pathologic) diagnosis.

d. Meetings: Surgical Review meetings shall be held at least quarterly and minutes kept of activities and forwarded to the MEC.

e. Risk Management: The committee may conduct peer review for Medical Staff risk management issues relevant to the committee duties as delineated in the Hospital Risk Management Plan.

8. *Pharmacy Committee*

a. Composition: This committee shall consist of at least two physician members of the Medical Staff and the Director of Pharmacy. Ex officio members may include representatives of Nursing Service, Administration and Health Information Management.

b. Meetings: The committee shall meet at least quarterly and send minutes to the MEC regarding its activities.

c. Duties: The committee shall be responsible for the development and surveillance of medications, drug utilization policies and practices associated with medication delivery in the organization.

d. The evaluation of drug usage includes the prophylactic, therapeutic, and empiric use of drugs and assures that they are provided appropriately, safely and effectively.

e. The committee shall assist in the formulation of policies and procedures regarding the evaluation, appraisal, selection, procurement, security, storage, distribution, use, safety procedures and all other matters relating to drugs in the organization. It shall also perform the following specific functions:

i. Serve as an advisory group to the Medical Staff and the Director of Pharmacy on matters pertaining to the choice of available drugs;

ii. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

iii. Develop and review periodically a formulary or drug list for use in the organization;

iv. Prevent unnecessary duplication in stocking drugs, including combinations having identical amounts of the same therapeutic ingredients;

v. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

vi. Establish standards concerning the use and control of investigative drugs;

vii. Provide education to the Medical Staff and Hospital staff relating to effectiveness, cost, risks and alternatives to medications.

f. Risk Management: The committee shall refer peer review for Medical Staff risk management issues that are beyond the scope of the committee to the relevant Medical Staff committee as delineated in the Hospital Risk Management Plan.

9. *Infection Control Committee*

a. Composition: The committee shall consist of at least one member of the Medical Staff and representatives from the various clinical departments and the Infection Control Coordinator. All regular attendees or their delegates may vote.

b. Meetings: The Infection Control Committee shall meet at least quarterly and a record of activities shall be kept and reported to the MEC.

c. Duties: The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of preventive and corrective programs designed to minimize infection hazards, review and application of standards and regulations pertaining to infection control, and the supervision of infection control in all phases of the Hospital's activities including:

i. Recommending policy, practice and equipment related to infection prevention in all areas of the organization including, but not limited to operating rooms, delivery rooms, special care units, emergency rooms, rural health clinics;

ii. Review of all sterilization and disinfection policies and procedures;

iii. Recommending isolation policies and procedures;

iv. Prevention of cross-infection by any clinical equipment or persons;

v. Testing, immunization and/or compliance of Medical Staff and Hospital personnel for specified diseases or carrier status;

vi. Disposal of infectious material;

vii. Other situations as requested by the MEC.

10. *Obstetrics Committee*

a. Composition: The OB Committee shall consist of at least three representatives of the Medical Staff who currently participate in newborn deliveries. Ex officio members may include the OB Supervisor, and representatives from Administration, Nursing Service, Respiratory Services, Anesthesia and Health Information Management.

b. Meetings: OB committee meetings shall be at least quarterly and minutes kept of activities are forwarded to the MEC.

c. Duties:

i. The committee shall be responsible for review of all obstetrical procedures and shall report at least quarterly to the MEC;

ii. OB review shall include, but not be limited to perinatal, neonatal and maternal deaths; readmissions; vaginal birth after C-section (VBAC); Cesarean section; labor induction, complications and transfers;

iii. Review shall include activities and policies of the entire OB service including the nursery.

d. Risk Management: The committee shall refer peer review for Medical Staff risk management issues beyond the scope of the committee to the relevant committee as delineated in the Hospital Risk Management Plan.

11. *Critical Care Committee*

a. Composition: The committee shall consist of at least four members of the Medical Staff and Hospital representatives from the Emergency Department and Intensive Care Unit. Ex officio members may include representatives of clinical departments, Administration and Health Information.

b. Meetings: The Critical Care Committee shall meet at least quarterly and minutes of activities shall be kept and reported to the MEC.

c. Duties:

i. Review activities related to critical care including, but not limited to Emergency Room, Intensive Care Unit, code blue response and emergency transfers;

ii. Establish policy and procedure related to critical care and make recommendations to other committees when appropriate;

iii. Review medical ethics issues on request.

d. The committee shall refer peer review for Medical Staff risk management issues beyond the scope of the committee to the relevant committee as delineated in the Hospital Risk Management Plan.

12. *Home Health Advisory Committee*

a. Composition: The committee shall consist of at least one member of the Medical Staff, the Director of Home Health and a community representative. Other members may include representatives of clinical departments, Administration and Health Information Management.

b. Meetings: The Home Health Advisory committee shall meet at least quarterly and minutes of activities shall be kept and reported to the MEC.

c. Duties:

i. Review activities related to home healthcare, including, but not limited to nursing and rehabilitation care, Lifeline and personal care;

ii. Oversight of medical record accuracy and appropriateness;

iii. Review State survey results and make recommendations actions for compliance;

iv. Approval of polices related to home care.

d. The committee shall refer peer review for Medical Staff risk management issues beyond the scope of the committee to the relevant committee as delineated in the Hospital Risk Management Plan.

13. *Cardiovascular Committee*

a. Composition: The committee shall consist of at least four members of the Medical Staff and hospital representatives from the Cardiac Catheterization Lab (CCL), Emergency Department (ED) and Intensive Care Unit (ICU). Ex officio members may include representatives of clinical and ancillary departments, Administration and Health Information Management (HIM).

b. Meetings: The Cardiovascular Committee shall meet at least quarterly and minutes of activities shall be kept and reported to the MEC.

c. Duties:
   i. Review activities related to the CCL including, but not limited to, ACC/NCDR Cath PCI National Registry, adverse events, door to balloon times, unplanned transfers, and ad hoc items.
   ii. Establish policy and procedure related to cardiac cath lab and make recommendations to other committees when appropriate; including education.
   iii. The committee shall refer peer review for Medical Staff risk management issues beyond the scope of the committee to the relevant committee as delineated in the Hospital Risk Management Plan.

14. Temporary Committees

Temporary committees may be formed at any time by the MEC. Examples include library services, Medical Staff Bylaws, equipment and special projects.

Revised 6/2021

Article X
Meetings

1. *Regular Meetings of the Medical Staff*

    a. Staff meetings shall be held at least semi-annually to review the performance of the Medical Staff; consider and act upon committee recommendations; provide opportunities for group education and communication between members and other Hospital leaders; and to conduct such other business as necessary.

    b. The Medical Staff meeting preceding the end of each medical staff year shall be the annual staff meeting at which regular elections of officers for the ensuing period shall be conducted.

    c. The Medical Executive Committee (MEC) shall, by standing resolution, designate the time and place for all regular staff meetings and shall notify all Active Medical Staff members in writing.

2. *Special Meetings of the Medical Staff*

    a. The President (Chief of Staff), the MEC, or not less than one-fourth of the members of the Active Medical Staff may at any time file a written request with the President that within 14 days of the filing of such request, a special meeting of the Medical Staff be called. The MEC shall designate the time, place and purpose of any such special meeting.

    b. Written or oral notice stating the place, day, hour and purpose of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active Staff; if in person, not less than three days, if by mail, not less than five days.

3. *Quorum*

    Fifty percent of the persons eligible to vote shall constitute a quorum at any meeting unless otherwise directed in these Bylaws.

4. *Manner of Action*

    The action of a majority of the members present at a meeting at which a quorum is present shall be sufficient. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat, unless otherwise directed in these Bylaws.

5. *Rights of Ex Officio Members*

    Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum and shall not vote.

6. *Minutes*

Minutes of each regular and special meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer. Copies thereof shall be submitted to the attendees for approval, and forwarded to the MEC and the Chief Executive Officer (CEO). The Hospital shall maintain a permanent file of the minutes of each meeting.

7. *Attendance Requirement*

Active Staff members are required to attend general Medical Staff meetings. Absences shall be reflected in meeting minutes and the MEC shall review attendance at least at reappointment. Other attendees at general meetings may include any member of the Medical Staff; members of Administration and the Board of Trustees; and Hospital department representatives and invited guests providing education or conducting business.

8. *Procedure*

Roberts Rules of Order shall be followed in all general Medical Staff and committee meetings.

Revised 6/2021

Article XI
Immunity From Liability

The following shall be express conditions of any member’s application for, or exercise of, clinical privileges at William Newton Hospital:

1. Any act, communication, report, recommendation, or disclosure, with respect to any such practitioner/professional, performed or made in good faith and without malice and at the request of an authorized representative of this or any other healthcare facility, for the purpose of achieving and maintaining quality patient care in this or any other healthcare facility, shall be privileged to the fullest extent permitted by law.

2. Such privilege shall extend to members of the Hospital's Medical Staff and of its Board of Trustees, its other practitioners/professionals, its Chief Executive Officer and all other Hospital employees, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this article the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative or the Board of Trustees or the Medical Staff.

3. There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

4. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other healthcare institution's activities related but not limited to:

    a. Applications for appointment or clinical privileges.

    b. Periodic reappraisals for reappointment or clinical privileges.

    c. Corrective action, including summary suspension.

    d. Hearings and appellate reviews.

    e. Medical care evaluations, including all Medical Staff quality improvement committees.

    f. Utilization reviews.

    g. Other Hospital, service or committee activities related to quality patient care and inter-professional conduct.

5. The acts, communications, reports, recommendations and disclosures referred to in these Bylaws may relate to a practitioner's/professional’s qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

6. In furtherance of the foregoing, each member shall upon request of the Hospital execute releases in accordance with the tenor and import of these bylaws in favor of the individuals and organizations specified in paragraph two, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Kansas.

7. The consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws for the protection of members of the Medical Staff, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this article.

8. Nothing in these bylaws should be construed to limit the protections of Kansas law for the confidentiality and non-discoverability of peer review documents, risk management records, Medical Staff and medical committee minutes, credentialing records, or other privileged or protected materials.

Reviewed 6/2021

Article XII
Rules & Regulations and Amendments

1. *Rules and Regulations*

   The William Newton Hospital Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within the Medical Staff Bylaws, subject to the approval of the Board of Trustees. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner and professional in the Hospital. Rules and Regulations shall be a part of these Bylaws. The various committees of the Medical Staff shall periodically review the Rules and Regulations relevant to the committee's responsibility and recommend changes to the Medical Executive Committee (MEC). All changes shall become effective only when approved by the Board of Trustees.

2. *Amendments*

   These Medical Staff Bylaws, Rules and Regulations may be amended after submission of the proposed amendment at, or preferably prior to, any regular or special meeting of the entire Medical Staff or the WNH MEC which a quorum is present. To be adopted, an amendment shall require a two-thirds majority vote in favor of the amendment of those members at the meeting who are eligible to vote. Amendments so made shall be effective when approved by the Board of Trustees. The Bylaws may not be amended unilaterally by the Medical Staff or the Board of Trustees. Members shall be informed of amendments to these Bylaws, Rules and Regulations.

Article XIII
General Provisions

1. Conduct

Appropriate conduct by members of the Medical Staff is essential for optimal patient care and the welfare of the Hospital. Members are expected to consistently demonstrate professional, ethical and cooperative behavior in the presence of, or when communicating with patients, visitors, Hospital staff and fellow members of the Medical Staff. Behavior that is derogatory, discriminatory, unnecessarily abrasive or which constitutes any form of harassment, including sexual harassment, will not be tolerated. Medical Staff members must report inappropriate conduct to the Chief of Staff and/or Chief Executive Officer (CEO).

2. Health of Practitioner/Professional

The health of a Medical Staff member is important not only for the welfare of the practitioner/professional, but also for patients, visitors, employees, volunteers and other members. Members with acute or chronic health problems that may interfere with patient care or put others at risk should seek appropriate care and arrange for coverage of their patients. Specific health issues are addressed in these Bylaws, Rules and Regulations and in departmental policies. The Hospital administration and the Medical Staff have the authority and obligation to intervene for the protection of those listed above.

3. Conflict of Interest

Although the mission and specific interests of the Hospital usually do not conflict with those of the member, the Board has the responsibility and authority to protect Hospital assets and to fulfill its charitable purposes by responding to financial competition. Medical Staff members may be considered to have a conflict of interest if they have existing or potential financial or other interests that impair or might reasonably appear to impair their independent, unbiased judgment in the discharge of their responsibilities to the Hospital and its patients. Members and applicants are required to report potential conflicts of interest at appointment/reappointment and anytime a potential conflict of interest arises. A conflict of interest may exist when a Medical Staff member or family member thereof:

a. Uses Hospital resources or confidential information about the Hospital to promote his or her individual or family's financial or other interests;

b. Has an employment or financial relationship with a competing hospital;

c. Assists an outside entity to benefit financially or otherwise benefit from the Hospital in ways not available to that entity's competitors;

d. Lends to or borrows money or property from an entity or person who conducts business with the Hospital, or;

e. Receives gifts from an individual or entity who conducts business with the Hospital.

4. Corporate Compliance

To ensure that its business practices are conducted with the highest of ethical standards, the Hospital has adopted a Corporate Compliance Plan. This plan requires the conduct of business in compliance with all applicable laws, regulations and standards and provides that any possible violations be reported to the Hospital's Compliance Officer. Members acknowledge and agree that in the performance of their duties they are expected to follow these same standards and to report any possible violations of laws, regulations, standards, or acceptable business practices.

5. Confidentiality

As a benefit of membership, members will frequently have access to information about patients, other staff members or Hospital employees, finances and plans that are requested to be, or inherently should be, kept confidential. At a minimum, members shall respect these requests. Breaches of confidentiality that violate Hospital policy or applicable law shall be referred to the Risk Manager or Medical Executive Committee (MEC) as appropriate. Each member agrees to comply with all privacy rules and other federal laws and regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including but not limited to the following:

a. Not use or further disclose patient's health information other than as permitted or required by Hospital policy or applicable law;

b. Use appropriate safeguards to prevent the inappropriate disclosure of the information;

c. Report to the Hospital any inappropriate use or disclosure of the information;

d. Require any agents and subcontractors who use the information to agree to the same restrictions and conditions that apply to practitioner/professional with respect to such information;

e. Make the information available for access and inspection upon request by the patient and/or Hospital;

f. Make the information available for amendment, and incorporate any amendments, upon request by the patient and/or Hospital. Unresolved amendment requests will be reviewed by the Health Information Committee;

g. Make the information available as required to provide the patient with an accounting of disclosures, upon request by Hospital;

h. Make member's internal practices, books, and records relating to the use and disclosure of protected health information available to the secretary of the Department of Health and Human Services as necessary to determine the Hospital's compliance with HIPAA; and

i. At termination of membership, if feasible, return or destroy all protected patient health information that member still maintains in any form and retain no copies of such information.

6. *Impaired Practitioner/Professional*

a. Impairment

WNH has a moral and legal obligation to protect patients, staff and Hospital assets from potential harm caused by an impaired practitioner/professional. Impairment is defined as an inability to practice the Medical Staff member's profession with reasonable skill and safety due to physical or mental disabilities, including but not limited to deterioration through the aging process, loss of motor skills, or influence of drugs or alcohol.

b. Hospital Intervention

As a condition of Medical Staff membership and clinical privileges, the Hospital shall intervene on behalf of the patient and/or require appropriate evaluation, which may include testing for mood-altering substances, if:

i. The practitioner/professional presents at the Hospital or related site with the intention of directly or indirectly participating in patient care; and

ii. In the opinion of Hospital staff or a member of the Medical Staff, the practitioner/professional appears at the time to be impaired in his or her ability to render care.

The CEO and the Chief of Staff or their delegates shall be notified immediately and shall assume that arrangements are made so that patient needs are met and, if appropriate, to request blood or urine testing for controlled or illegal substances or alcohol.

At the judgment of the CEO and the Chief of Staff, the practitioner/professional may resume privileges if impairment is no longer apparent and the results of any testing are negative for controlled or illegal substances, or alcohol. All such events will be reviewed by the MEC and Board of Trustees no later than the next scheduled meeting at which time further actions may be initiated.

A practitioner/professional who tests positive for illegal or controlled substances or alcohol or who fails to submit to an evaluation or refuses to produce samples under supervision shall be suspended from clinical privileges pending review by the MEC.

7. *Drug Free Workplace*

WNH is a Drug Free Workplace. Having detectable amounts of illegal substances or alcohol in your system or the unlawful manufacture, use, possession, distribution, sale or purchase of illegal substances by any member of the Medical Staff while on Hospital premises, in any Hospital owned or operated building or vehicle, or while conducting patient care or Hospital business, is prohibited.

8. *Grievances*

Members of the Medical Staff are encouraged to resolve grievances in a timely and professional manner to avoid unnecessary problems. If a problem persists, the member should speak with the Chief of Service, Chief of Staff or CEO as appropriate. If the member is still not satisfied, the grievance should be directed to the MEC or Board of Trustees, as appropriate, in writing.

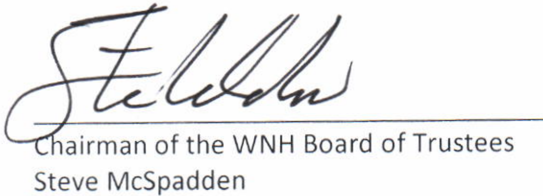
WNH MEDICAL STAFF BYLAWS

ARTICLE XIV

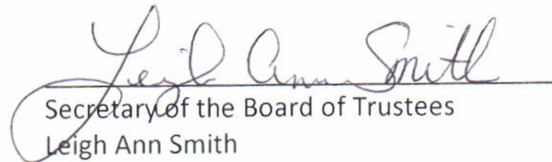
ADOPTION

These William Newton Hospital Medical Staff Bylaws, together with the appended Rules and Regulations, shall be reviewed at least every three years. The Medical Executive Committee has the responsibility and authority to review sections as needed and recommend revision for Board of Trustees approval at any time. Such recommendations may also occur at any regular or special meeting of the Active Medical Staff. These Bylaws shall replace any previous bylaws, rules and regulations, and shall become effective when approved by the Board of Trustees of the Hospital.

APPROVED by the Board of Trustees on June 21, 2021.



Chairman of the WNH Board of Trustees
Steve McSpadden



Secretary of the Board of Trustees
Leigh Ann Smith