INTRODUCTION

The Hospital is operated under the laws of the State of Oklahoma to serve as a general health care facility providing patient care with all the activities subject to the ultimate authority of the Board of Directors.

The principal purpose of the Hospital is to provide patient care at a level of quality and efficiency consistent with generally accepted guidelines, and otherwise to fulfill professional and institutional obligations to patients and the community.

The dedication to this purpose requires the joint efforts of the practitioners practicing in the Hospital facilities and the Board and Hospital Administration with well-defined lines of communication, responsibility and authority throughout the organizational structure.

The laws, regulations, customs and generally recognized professional guidelines that govern hospitals require that all practitioners practicing at a hospital be appointed to the Medical Staff and that the Board of Directors must delegate to the Medical Staff responsibilities relating to an accountability for the quality, efficiency and overall appropriateness of practitioner performance.

These Bylaws and related manuals are formulated to establish the framework to which the Medical Staff shall function and carry out the delegated responsibilities consistent with the Bylaws, policies and rules of the Hospital.

This document is not intended to create an agreement between the Hospital and any individual physician.
ARTICLE 1: GENERAL INFORMATION

1.1 DEFINITIONS

The following definitions apply to the provision of these Medical Staff Bylaws and its related manuals. The definitions are in alphabetical order.

A. "Senior Vice President of Operations" means the individual appointed by the Board of Directors to act in its behalf in the overall management of the hospital. The title of this individual may be Senior Vice President of Operations, Vice President of Operations, or Administrator.

B. "Board of Directors" or "Board" means the governing body of Saint Francis Health System, or as appropriate to the context, any committee or individual authorized by the Board to act on its behalf on certain matters.

C. "Clinical Privileges" means permission granted by the Board to a practitioner to provide those diagnostic or therapeutic medical or surgical services specifically delineated to him.

D. "Ex officio" means service as a member of a body by virtue of office or position held and with or without vote as specified.

E. "Hospital" means Saint Francis Hospital South.

F. "Medical Executive Committee" (MEC) means the committee composed of Medical Staff officers and elected members that represent all Staff members and provides them with the medical and administrative leadership necessary to fulfill the Staff's accountability to the Board for the quality and efficiency of patient care.

G. "Medical Staff" means all physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board.

H. "Medical Staff Leader" means any Medical Staff officer, medical director, and committee chair.

I. "Member" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

J. "Medical Staff Bylaws or related Medical Staff documents" means any one or more of the following documents as appropriate to the context of:

1. Bylaws of the Medical Staff
2. Medical Staff Credentialing Procedure Manual
3. Medical Staff Fair Hearing Plan
4. Rules and Regulations of the Medical Staff
5. Procedures to Address Impaired or Disruptive Physicians
6. Impaired Professional Program
7. Allied Health Professionals Credentialing Policy and Fair Hearing Plan

K. "Medical Staff Year" means the 12-month period beginning on January 1 of each year and ending on December 31 of the same year.

L. "Physician" means an individual with an M.D. or D.O. degree who is licensed to practice medicine.

M. "Special Notice" means notification by certified mail with a request for a return receipt.

N. "Proctor" means an Active Staff member who has been assigned to act as Supervisor or Sponsor of an individual with provisional clinical privileges.

1.2 NAME

The organizational component of the Hospital to which these Bylaws and the related Medical Staff documents are addressed is called the Medical Staff of Hospital.

1.3 EFFECTIVE DATE

These Medical Staff Bylaws shall become effective on June 1, 2007, or upon such earlier date as the transition to the new Hospital facility is finalized. Upon adoption of these Bylaws and related Medical Staff documents, all new appointments to Saint Francis Hospital South will be governed by the terms set forth herein.
ARTICLE 2: MEDICAL STAFF CATEGORIES

2.1 ACTIVE STAFF

2.1.1. Qualifications

The active staff shall consist of those qualified physicians, dentists and podiatrists who desire to practice actively at Saint Francis Hospital South. Individuals appointed to this category must demonstrate their interest in and commitment to the hospital not only through active clinical practices, but also through active participation in medical staff activities and responsibilities. Specifically, the active staff shall consist of individuals who:

a. Are located (office and residence) within the geographic service area of the hospital as defined by the board, close enough to fulfill their medical staff responsibilities and to provide timely and continuous care for their patients in the hospital;

b. Center a major portion of their practice in the hospital and its outpatient programs (at least 12 patient managements per year); and

c. Are active in medical staff activities and responsibilities, such as committee assignments.

2.1.2. Responsibilities

Each appointee to the active staff, by accepting appointment, shall agree to:

a. Assume all the functions and responsibilities of appointment to the active staff, including, where appropriate, care for unassigned patients, emergency service care and consultation and teaching assignments;

b. Attend medical staff meetings;

c. Serve on medical staff committees, as assigned;

d. Faithfully perform the duties of any office or position to which elected or appointed;

e. Participate in performance improvement and monitoring activities as may be assigned by committee chairpersons, including the evaluation of provisional appointees; and

f. Pay all staff dues and assessments.
2.1.3. Prerogatives

Active staff appointees shall:

a. Be entitled to vote, hold office, serve on medical staff committees, and serve as chairpersons of such committees;

b. Be entitled to admit and treat patients within the limits of their assigned clinical privileges;

c. Be entitled to meet with the Medical Executive Committee (MEC) regarding any grievance or issue, as long as an effort has first been made to address the issue through the chief of staff, without success (in this situation, the individual must give two weeks' notice of the matter to the chief of staff); and

d. Be entitled to attend and observe meetings of the MEC, without vote, so long as two weeks' notice is given to the Chief of Staff. Participation in such meetings may be limited by the Chief of Staff and the active appointee will be asked to leave for any discussion of confidential peer review issues.

2.1.4. Treatment at Age 65

Active staff who have attained the age of 65 years shall be treated as follows:

a. In accordance with Section 4.A.7 of the credentialing policy, the credentials committee shall specifically consider the mental and physical capabilities of each appointee to the active staff who continues to exercise clinical privileges. These individuals shall be reappointed on an annual basis;

b. Upon attaining the age of 75, medical staff appointees shall automatically advance to the honorary staff (unless an exception is recommended by the credentials committee and the Medical Executive Committee, and approved by the Board. Such exceptions shall be rare and shall be limited to circumstances when the services offered by the individual cannot otherwise be provided adequately by the hospital or its medical staff); and

c. Appointees at the age 65 may be exempt from emergency service care responsibilities and from committee assignments, unless they request otherwise.
2.2 COURTESY STAFF

2.2.1. Qualifications

The courtesy staff shall consist of physicians, dentists and podiatrists of demonstrated competence qualified for staff appointment, who:

a. Are not eligible for appointment to the active staff because they center only a minor portion of their practice at the hospital (less than 12 patient managements per year);

b. Are located (office and residence) within the geographic service area of the hospital, as defined by the board, close enough to fulfill their medical staff responsibilities and to provide timely and continuous care for their patients in the hospital;

c. Hold an active staff appointment at another hospital unless exception made by the Credentials Committee and Medical Executive Committee; and

d. At each reappointment time, provide evidence of clinical performance at his/her primary hospital in such form as may be required by the Credentials Committee, the Medical Executive Committee, or the Board in order to allow for an appropriate assessment of continued qualifications for medical staff appointment and clinical privileges.

2.2.2. Responsibilities

Each appointee to the courtesy staff:

a. May attend general and special staff meetings;

b. Shall assume all functions and responsibilities as assigned,

c. Shall have no staff committee responsibilities; and

d. Shall pay all staff dues and assessments.

2.2.3. Prerogatives

Courtesy staff appointees:

a. May not serve on staff committees, may not vote, and may not hold office; but
b. Shall be entitled to admit and treat patients (pursuant to Section 2.B.1) within the limits of their assigned clinical privileges; and

c. Are permitted to use the hospital’s diagnostic facilities without limitation.

2.3 ACTIVE-AFFILIATE STAFF

2.3.1. Qualifications

a. The active-affiliate staff shall consist of those physicians, dentists and podiatrists who desire to be associated with, but who do not intend to establish a clinical practice at the hospital. The primary purpose of the active-affiliate staff is to promote professional and educational opportunities, including continuing medical education endeavors, and to permit such individuals to access hospital services for their patients by direct referral of inpatients to other appointees of the medical staff for admission, evaluation, and/or care and treatment.

b. Individuals requesting appointment to the active-affiliate staff must submit an application as prescribed by the credentialing policy. They shall not, however, be required to satisfy all the qualifications set forth in Section 1.A.1 (c through l) of the credentialing policy.

2.3.2. Prerogatives and Responsibilities

Active-affiliate staff appointees:

a. Shall be entitled (but not required) to attend meetings of the medical staff without vote. If the appointee has been assigned to serve as a member of a medical staff committee, he/she shall be granted voting privileges;

b. Shall be entitled to attend educational programs of the medical staff;

c. Shall be entitled to refer inpatients to active staff physicians at the hospital, visit those patients when hospitalized and review their medical records, but may not write orders or make medical record entries;

d. Shall be permitted to use the hospital’s outpatient diagnostic and infusion therapy facilities;

e. Shall not be granted clinical privileges and shall not admit or treat patients at the hospital;

f. Shall pay all staff dues and assessments; and
g. Shall assume all functions and responsibilities as assigned, including follow-up care for unassigned patients (applicable only to Internal Medicine & Family Practice physicians).

The grant of appointment as an active-affiliate staff member is a courtesy only, which may be terminated by the board (or its designee) upon recommendation of the Credentials Committee, without rights to the hearing and appeal procedures set forth in the credentialing policy.

Any active-affiliate staff member who wishes to transfer to another staff category shall complete and submit an application requesting such change. That application will then be processed pursuant to the terms and conditions set forth in these bylaws and in the credentialing policy.

2.4 HONORARY STAFF

2.4.1. Qualifications

The honorary staff shall consist of physicians, dentists and podiatrists who are honored for their contribution to Saint Francis Hospital South or those who have retired from active hospital practice and still have an interest in the hospital.

2.4.2. Prerogatives

Persons appointed to the honorary staff shall not be eligible to admit or attend patients, to vote, to hold office, or to serve on standing medical staff committees, but may be appointed to special committees. They may attend any medical staff meetings. They shall not be required to pay any dues or assessments.
ARTICLE 3: OFFICERS

3.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

A. President/Chief of Staff
B. President Elect
C. Vice President
D. Secretary/Treasurer

The President Elect shall ascend to the office of Chief of Staff one (1) year from the time of taking office as President Elect.

3.2 QUALIFICATIONS OF OFFICERS

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

A. Be appointed in good standing to the Active Staff, and have served on the Active Staff for at least three years;
B. Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
C. Not presently be serving as a Medical Staff officer, Board member or department chief at any other hospital and shall not so serve during their term of office;
D. Disclose any other financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with any entity that competes with the Hospital or any affiliate on at least an annual basis and when changes occur. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. After considering the recommendation of the MEC, the Board shall determine whether any such relationship disqualifies the member from serving in a Medical Staff leadership position;
E. Be willing to faithfully discharge the duties and responsibilities of the position;
F. Have experience in a leadership position, or other involvement in performance improvement functions for at least two years;
G. Attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office; and

H. Have demonstrated an ability to work well with others.

3.2.1. Failure to maintain the above requirements shall immediately create a vacancy in the office involved.

3.3 ELECTION OF OFFICERS

3.3.1. Officers shall be elected annually in December by members of the Active Medical Staff eligible to vote.

3.3.2. The Nominating Committee shall consist of members of the Active Medical Staff appointed by the Chief of Staff and shall be chaired by the President Elect. This committee shall offer a minimum of two (2) nominations for the office of President Elect. Candidates for the four (4) member-at-large positions will be nominated by the Nominating Committee.

3.3.3. The report of the Nominating Committee shall be publicized to the voting members of the Staff a minimum of twenty (20) days prior to the annual December meeting.

3.3.4. Nominations may be made from the general staff in writing no later than ten (10) days prior to the annual December meeting. Each nomination must be supported by signatures of six (6) Active Staff members.

3.3.5. The elections shall be conducted by secret ballots mailed to all members of the Active Medical Staff entitled to vote along with self-addressed stamped envelopes. The vote of a majority of the Active Staff members who return their ballots within the specified time period is required for election.

3.3.6. A nominee for one office shall be eligible for other offices. Each officer shall be elected separately.

3.4 TERM OF OFFICE

Officers shall take office on the first day of the Medical Staff year. The Chief of Staff will serve a term of two years. All other officers' term of office shall be for one year.

3.5 VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the Medical Executive Committee of the Medical Staff. If there is a vacancy in the office of the Chief of Staff, the Vice President shall serve out the remaining term.
3.6 DUTIES OF OFFICERS

3.6.1. Chief of Staff: The Chief of Staff shall serve for two years as the Chief Administrative Officer of the Medical Staff and shall be responsible for the following:

a. Act in coordination and cooperation with the Administrator in all matters of mutual concern within the hospital.

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

c. Serve as Chairman of the Medical Staff Executive Committee.

d. Serve as *ex officio* member of all other Medical Staff committees without vote.

e. Be responsible for the enforcement of Medical Staff Bylaws, Policies and Procedures, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

f. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Administrator.

g. Receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

h. Be responsible for the educational activities of the Medical Staff.

i. Be the spokesman for the Medical Staff in its external professional and public relations.

3.6.2. President Elect: In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/she shall be a member of the Medical Executive Committee of the Medical Staff and shall chair the Credentials Committee. He/she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason. He/she shall succeed to the office of Chief of Staff one (1) year from the time of assuming office.

3.6.3. Vice President: In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He shall be a member of the Medical Executive Committee of the Medical Staff and shall chair the Credentials Committee. He/she shall automatically succeed the Chief of Staff when the latter
fails to serve for any reason. The Vice President will be elected on alternating years that follows the election of the President Elect. His/her term of office will be for one year.

3.6.4. Secretary/Treasurer: He/she shall be a member of the Medical Executive Committee of the Medical Staff. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to his office.

3.7 REMOVAL OF ELECTED OFFICIALS FROM OFFICE

The Medical Executive Committee, by a two-thirds vote, may remove any Medical Staff officer or any member of the Medical Executive Committee for conduct detrimental to the interests of the Hospital, failure to perform the duties of the position, or if the individual is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office, provided that notice of the meeting at which such action shall be decided is given in writing to such individual at least ten days prior to the date of the meeting. The officer or member of the Medical Executive Committee shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

Removal of an elected official during his term of office may be initiated by a two-thirds majority vote of all Active Medical Staff members, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and by the Board.

In addition, an officer or member of the Medical Executive Committee who is found to no longer meet any of the general or specific qualifications for the office (including those set forth in Article 3.2) shall automatically relinquish his/her office.

3.8 MEDICAL REPRESENTATION ON THE BOARD OF DIRECTORS

Refer to the Board of Directors' Bylaws.
ARTICLE 4: COMMITTEES

4.1 PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff, through its committees or designated individuals, is actively involved in the measurement, assessment, and improvement of at least the following:

A. patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

B. the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

C. medical assessment and treatment of patients;

D. medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

E. the utilization of blood and blood components, including review of significant transfusion reactions;

F. operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

G. appropriateness of clinical practice patterns;

H. significant departures from established patterns of clinical practice;

I. use of information about adverse privileging determinations regarding any practitioner;

J. the use of developed criteria for autopsies;

K. sentinel events, including root cause analyses and responses to unanticipated adverse events;

L. nosocomial infections and the potential for infection;

M. unnecessary procedures or treatment;

N. appropriate resource utilization;

O. education of patients and families;
P. coordination of care, treatment, and services with other practitioners and Hospital personnel;

Q. accurate, timely, and legible completion of medical records;

R. the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in the Medical Staff Rules and Regulations;

S. review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

T. communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff appointees and the Board.

4.2 MEDICAL EXECUTIVE COMMITTEE

4.2.1 Composition: The Medical Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff and four (4) members-at-large. The Administrator and the Director of Nursing or their respective designees shall be members, ex officio, without vote. No one will be ineligible for membership on the Medical Executive Committee because of their discipline or specialty.

4.2.2 Candidates for the four (4) member-at-large positions will be nominated by the Nominating Committee. Announcement of nominations for the member-at-large positions will be made to the voting members of the Medical Staff a minimum of twenty (20) days prior to the annual meeting. Additional nominations from the Staff must be made at least ten (10) days prior to the annual meeting and must be supported by the signatures of six (6) Active Staff members.

4.2.3 Duties of the Medical Executive Committee shall be:

A. To represent and to act on behalf of the Medical Staff in the intervals between Medical Staff meetings subject to such limitations as may be imposed by these Bylaws.

B. To coordinate the activities and general policies of the various services.

C. To recommend directly to the Board on at least the following.

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;
(3) applicants for Medical Staff appointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) other appropriate reports and recommendations that the MEC has received from Medical Staff committees, departments, and other groups.

D. To implement rules and regulations of the Medical Staff.

E. To provide liaison between the Medical Staff, the Administrator and the Board.

F. To recommend action to the Administrator on matters of medico-administrative nature.

G. To make recommendations on hospital management (for example, long-range planning) to the Board through the Administrator.

H. To fulfill the Medical Staff's accountability to the Board for the medical care rendered to the patients in the hospital.

I. To insure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital.

J. To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.

K. To take all reasonable steps to insure professionally 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.

L. To report at each general staff meeting.

M. The President Elect or Vice President, Secretary/Treasurer and members-at-large will serve as chairmen of the standing medical staff committees.
N. Each chairman shall have the authority to select other members of the Active Staff to assist him with the functions of his position.

O. To undertake any and all such other actions as are necessary to insure satisfactory compliance with the provisions of the Bylaws.

P. To consult with administration on quality-related aspects of contracts for patient care services.

4.2.4 Meetings:

The Medical Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions. Reports of all actions and recommendations are communicated to the Board or its designated body.

4.3 CREDENTIALS COMMITTEE

4.3.1 The Credentials Committee shall be chaired by the President Elect or Vice President.

4.3.2 The Credentials Committee shall be composed of the President Elect or Vice President and a minimum of three (3) members of the Active Medical Staff selected by the Chairman and subject to the approval of the Chief of Staff, Administrator and Board.

4.3.3 The three Active Staff members will serve a minimum of two (2) years and may succeed themselves.

4.3.4 The Credentials Committee shall have the following functions:

A. Review the credentials of all applicants and make recommendations regarding initial appointments and delineation of clinical privileges.

B. Peer review including periodic reappraisals of the performance and clinical competence of staff members and other practitioners with clinical privileges.

C. Make recommendations for reappointments and renewal or changes in clinical privileges.

4.3.5 The Committee shall meet at least monthly to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.
4.4 PHARMACY & THERAPEUTICS COMMITTEE

4.4.1 The Pharmacy & Therapeutics Committee shall be chaired by the Secretary/Treasurer of the Medical Staff.

4.4.2 Duties shall include the following:

   A. Responsible for the development and surveillance of all drug utilization policies and procedures within the hospital in order to assure optimum clinical results and patient safety. These policies shall address the evaluation, selection, procurement, storage, distribution, safe use and all other matters relating to drugs in the hospital.

   B. Develop, periodically review and make recommendations to the hospital formulary.

   C. Monitor the use of drugs through a criteria-based, ongoing and systematic process.

4.4.3 The Committee shall meet at least quarterly to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.

4.5 BYLAWS COMMITTEE

4.5.1 The Bylaws Committee shall be chaired by the Secretary/Treasurer of the Medical Staff.

4.5.2 Duties shall include annual review of the Medical Staff Bylaws and related manuals.

4.5.3 The Bylaws Committee shall meet at least annually to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee and Active Medical Staff.

4.6 QUALITY IMPROVEMENT COUNCIL

4.6.1 The Quality Improvement Council shall be chaired by Member-at-Large (Position A).

4.6.2 This Committee shall be responsible for the following:

   A. Supervising the components of the Organizational Performance Improvement and Patient Safety Plan.
B. Overseeing and directing the performance improvement and patient safety efforts of the Medical Staff.

C. Monitoring quality data on clinical matters in a systematic fashion from all available sources.

D. Alerting the Medical Executive Committee of any significant deficits, either individually or collectively, in quality of care or patient safety.

E. Participating as needed in sentinel event case review and risk management activities.

F. Collaborating with the Quality Department, hospital staff, and any other relevant clinical personnel, as appropriate, to accomplish the above functions.

G. Working with other Medical Staff committees, as appropriate to accomplish the above functions.

H. Medical record review including timely completion, pertinence and overall adequacy.

4.6.3 The Quality Council shall meet monthly to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee and the Medical Staff and Quality Committee of the Board.

4.7 PROFESSIONAL PRACTICE COMMITTEE

4.7.1 This Committee shall be chaired by Member-at-Large (Position B).

4.7.2 This Committee shall be responsible for the following:

A. Establishing and overseeing a standardized peer review process for staff appointees.

B. Monitoring the performance of practitioners who have privileges.

C. Identifying opportunities for performance improvement.

D. Monitoring significant trends by analyzing aggregate data.

4.7.3 This Committee shall meet at least every other month to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.
4.8 CRITICAL CARE COMMITTEE

4.8.1 This Committee shall be chaired by Member-at-Large (Position C).

4.8.2 Duties include the following:

A. Review and make recommendations on policies and procedures that govern the Intensive Care Unit, Emergency and Trauma Services.

B. Review the quality of care provided to patient admitted to the Intensive Care Unit.

C. Oversee Trauma Registry reporting.

D. Perform mortality review.

E. Multi-disciplinary peer review of trauma and emergency cases.

F. Review times and reasons for trauma-related bypass.

G. Review the availability and response times of on-call staff specialties.

H. Assist in implementation of inservice education for nursing personnel.

I. Review code blues.

4.8.3 This Committee shall meet at least quarterly to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.

4.9 UTILIZATION REVIEW COMMITTEE

4.9.1 This Committee shall be chaired by Member-at-Large (Position D).

4.9.2 Duties include the following:

A. Evaluate the appropriateness of admissions to the hospital, length of stay, use of medical and hospital services, and all other related factors which may contribute to the effective utilization of hospital and physician services.

B. Evaluate the continuity of patient care.

C. Communicate the results of utilization studies and other pertinent data to the Medical Staff and make recommendations for optimum utilization of
hospital resources and facilities commensurate with quality of patient care and patient safety.

D. Shall formulate a written utilization review plan for the hospital.

E. Shall evaluate the medical necessity for continued hospital services for specific patients when appropriate.

4.9.3 This Committee shall meet at least quarterly to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.

4.10 PHYSICIAN HEALTH COMMITTEE (PHC)

4.10.1 The Chief of Staff shall appoint the Physician Health Committee. It shall be composed of no fewer than three (3) Active Medical Staff members.

4.10.2 The Chairman of the Physician Health Committee shall be senior physician who has an interest in physician health and well being.

4.10.3 Committee members may be selected from the Active Medical Staff based on their interest in physician health and well being and their willingness to serve.

4.10.4 Committee responsibilities will include the following:

A. Receive and investigate reports regarding individual physician behavior from any source. Reports may be written or oral at the committee meeting or given in confidence outside of the formal meeting to a member acting under the auspices of the Credentials Chairman, Chief of Staff or Chairman of the PHC;

B. Discuss observations and findings regarding physicians who have been referred to the committee or about whom the committee has received reports;

C. Invite physicians to committee meetings to discuss personal problems. Physicians who decline to attend may be discussed in absentia, a file may be opened, and recommendations made to the Chief of Staff, when appropriate;

D. Identify appropriate community sources for inpatient or outpatient patient care;

E. Participate in organized efforts to induce the physician to enter therapy;
F. Negotiate monitoring agreements as part of a structured program of rehabilitation. Only the Chief of Staff or the Chairman of the PHC may sign agreements if formally designated;

G. Organize and supervise the clinical and professional performance evaluation of physicians exercising practice privileges under a monitoring agreement. Performance evaluation may include random mandatory supervised urine, blood or breath testing or neurophysiologic or other medical or psychiatric evaluation. The committee may also receive reports from medical staff proctoring or peer review functions confidentially via the Chief of Staff.

H. Receive reports from physicians or other treating agencies responsible for the professional care of a member of the Medical Staff.

I. Recommend to the MEC policies, procedures, and programs for the promotion of health and wellness of members of the Medical Staff and hospital personnel;

J. Recommend to the MEC specific fitness criteria for use in the evaluation of privilege requests.

4.10.5 This Committee shall meet as needed, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.

4.11 CREATION OF STANDING COMMITTEES

4.11.1 The Medical Executive Committee may, without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions.

4.11.2 Special committees shall be created, and their members and chairpersons shall be appointed by the Chief of Staff. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Medical Executive Committee.
ARTICLE 5: MEDICAL STAFF MEETINGS

5.1 MEDICAL STAFF MEETINGS

5.1.1. Regular Meetings:

The Medical Staff shall meet at least once a year.

5.1.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, the Board, or by a petition signed by not less than one fourth of the Active Staff.

5.2 COMMITTEE MEETINGS

5.2.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each committee shall meet at least quarterly, at times set by the presiding officer.

5.2.2. Special Meetings:

A special meeting of any committee may be called by or at the request of the presiding officer, the Chief of Staff, or by a petition signed by not less than one-fourth of the Active Staff members of the committee, but not by fewer than two members.

5.3 PROVISIONS COMMON TO ALL MEETINGS

5.3.1. Notice of Meetings:

A. Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of committees at least two weeks in advance of the meetings. Notice may also be provided by posting in a designated location at least two weeks prior to the meetings. All notices shall state the date, time, and place of the meetings.

B. When a special meeting of the Medical Staff or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). Posting may not be the sole mechanism used for providing notice.
C. The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

5.3.2. Quorum, Agenda, and Voting:

A. For any regular or special meeting of the Medical Staff or committee those voting members present shall constitute a quorum. However, for meetings of the Medical Executive Committee and the Credentials Committee, the presence of at least 50% of the voting members of the Committee shall constitute a quorum.

B. The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff or committee. Action may be taken only on those items noted on the agenda. Any new item must be either deferred to the next meeting or presented to the voting members in accordance with paragraph (d) of this section.

C. Recommendations and actions of the Medical Staff and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.

D. The voting members of the Medical Staff or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the presiding officer by the method designated in the notice. Except for actions by the Medical Executive Committee or Credentials Committee (which require a 50% quorum), a quorum for purposes of these votes shall be the number of responses returned to the presiding officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

E. Meetings may be conducted by telephone conference.

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws, and Medical Staff or committee custom shall prevail at all meetings, and the presiding officer shall have the authority to rule definitively on all matters of procedure.

5.3.3. Minutes, Reports, and Recommendations:

A. Minutes of all meetings of the Medical Staff and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.
B. A summary of all recommendations and actions of the Medical Staff and committees shall be transmitted to the Medical Executive Committee and the Vice President of Operations. The Board shall be kept apprised of the recommendations of the Medical Staff and its committees.

C. A permanent file of the minutes of all meetings shall be maintained by the Hospital.

5.3.4. Confidentiality:

Members of the Medical Staff who have access to credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes. A breach of confidentiality may result in the imposition of disciplinary action.

5.3.5. Attendance Requirements:

Each Active Staff member is expected to attend and participate in all Medical Staff meetings and committee meetings each year.
ARTICLE 6: INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, committee chairmen, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's bylaws.
ARTICLE 7: GENERAL PROVISIONS

7.1 STAFF DUES

The Medical Executive Committee will establish the amount, if any, of annual dues. Notice of dues will be given to the Staff at the beginning of each year. Dues are payable on or before March 1 of each year. If dues are not received by March 15, a special notice of delinquency is sent to the practitioner and he is given an additional 30 days to make payment. Failure to render payment at that point shall, unless excused by the Medical Executive Committee for good cause, result in summary suspension of Staff membership and clinical privileges until the delinquency is remedied. All new Staff members will be billed pro rata for the current year upon their appointment to the Staff. Special assessments may be voted by action of the Medical Staff, and rules of payment similar to those described above in terms of time frame will apply.

7.2 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws and related manuals will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws and related manuals are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws and related manuals.
ARTICLE 8: BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentialing Policy and the Allied Health Professionals Credentialing Policy in a more expansive form.

8.1 QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentialing Policy and Allied Health Professionals Credentialing Policy.

8.2 PROCESS FOR PRIVILEGING

Complete applications are transmitted to the Credentials Committee, which shall designate an Initial Physician Reviewer, who prepares a written report to the Credentials Committee which then prepares a recommendation and forwards it, along with the Initial Physician Reviewer's report, to the Medical Executive Committee for review and recommendation and to the Board for final action.

8.3 PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are transmitted to the Credentials Committee, which shall designate an Initial Physician Reviewer, who prepares a written report to the Credentials Committee which then prepares a recommendation and forwards it, along with the Initial Physician Reviewer's report, to the Medical Executive Committee for review and recommendation and to the Board for final action.

8.4 INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

8.4.1 Appointment and clinical privileges may be automatically relinquished if an individual:

A. fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information; and

(iv) attend a special conference to discuss issues or concerns;
B. is involved or alleged to be involved in defined criminal activity;

C. makes a misstatement or omission on an application form; or

D. is subject to a suspension, restriction, limitation, or condition in another SFHS Hospital.

8.4.2 Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.5 INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

8.5.1 Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief of Staff, the Credentials Committee Chair, the Vice President of Operations, the Board Chair, or the Medical Executive Committee is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

8.5.2 A precautionary suspension is effective immediately and will remain in effect unless it is modified by the Medical Executive Committee or Vice President of Operations.

8.5.3 The Medical Executive Committee will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

8.5.4 Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Medical Executive Committee.

8.6 INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

A. Following an investigation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges based on concerns about: the clinical competence or clinical practice of any Medical Staff appointee;

B. the care or treatment of a patient or patients or management of a case by any Medical Staff appointee;

C. the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the Hospital or its Medical Staff, including, but not limited to, the Hospital's performance improvement, risk management, and utilization review programs; or
D. behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others.

8.7 HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

8.7.1 The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

8.7.2 The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

8.7.3 The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

8.7.4 A stenographic reporter will be present to make a record of the hearing.

8.7.5 Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
   a. to call and examine witnesses, to the extent available;
   b. to introduce exhibits;
   c. to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
   d. to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;
   e. to submit a written statement at the close of the hearing; and
   f. to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

8.7.6 The personal presence of the affected individual is mandatory. Any individual requesting a hearing who does not testify in his or her own behalf may be called and examined as if under cross-examination.

8.7.7 The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

8.7.8 The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel to the Board.
ARTICLE 9: ADOPTION AND AMENDMENT

9.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board holds the Medical Staff responsible for the development, adoption, and periodic review of Medical Staff Bylaws, which must be consistent with Hospital policies, applicable laws, and other requirements. The Medical Staff Bylaws and related manuals shall be reviewed at least annually by the Medical Executive Committee. Suggestions for changes in the Bylaws shall be referred to the Medical Executive Committee. The adoption and amendment of Medical Staff Bylaws require the actions specified in Sections 9.2. The Medical Executive Committee will act for the Staff in adopting and amending the related manuals developed to implement various Sections of these Bylaws.

Neither the Board of Directors nor the Medical Staff may change these Bylaws unilaterally.

9.2 MEDICAL STAFF BYLAWS

9.2.1 Amendments to these Bylaws may be proposed by a petition signed by at least 25% of the members of the Active Staff, by the Bylaws Committee, or by the Medical Executive Committee.

9.2.2 All proposed amendments must be reviewed and discussed by the Medical Executive Committee prior to a Medical Executive Committee vote. Such amendments may be recommended to the Board of Directors by the Medical Executive Committee after a majority vote, provided that the proposed amendment was first distributed to the members of the Active Staff at least 21 days prior to an Medical Executive Committee vote. The Medical Executive Committee's recommendation may be acted upon by the Board if approved by the Active Staff. Proposed amendments will be mailed to all members of the Active Staff entitled to vote with a self-addressed envelope. The affirmative vote of a majority of the Active Staff members who return their ballots is required for amendment of these Bylaws. If the majority of the Active Staff members who return their ballots object to the proposed amendment, the Chief of Staff or the Medical Executive Committee may elect to bring the proposal before the Active Medical Staff at a called or regularly scheduled meeting at which time the amendment will be discussed and voted upon. The affirmative vote of a majority of those active staff members present and voting is required for passage (absentee ballots will be permitted). If significant changes are made in the Medical Staff Bylaws, rules and regulations, or policies, Medical Staff members and other individuals who have delineated clinical privileges will be provided with revised texts of the materials.
9.2.3 When Medical Staff recommendations are approved upon the affirmative vote of a majority of the Board, the effective date of such approved recommendations is on the date approved or at such later date as the Board may specify.

9.2.4 The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical, non-substantive modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within 90 days of adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated by some reasonable mechanism and in writing to the Staff and the Board.

9.3 OTHER MEDICAL STAFF DOCUMENTS

9.3.1 In addition to the Medical Staff Bylaws, there shall be policies, procedures, and rules and regulations that are applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, but amended in accordance with this Section.

9.3.2 An amendment to the Credentialing Policy or the Allied Health Professionals Credentialing Policy may be made by a majority vote of the members of the Medical Executive Committee, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments to these two documents shall also be provided to each member of the Active Staff at least 14 days prior to the vote by the Medical Executive Committee. Any member of the Active Staff may submit written comments on the amendments to the Medical Executive Committee.

9.3.3 An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to this document shall be provided to each member of the Active Staff at least 14 days prior to the vote by the Medical Executive Committee. Any member of the Active Staff may submit written comments on the amendments to the Medical Executive Committee.

9.3.4 All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.
9.3.5 Amendments to Medical Staff policies and to the Rules and Regulations may also be proposed by a petition signed by at least 25% of the members of the Active Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

9.3.6 Adoption of and changes to the Credentialing Policy, Allied Health Professionals Credentialing Policy, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

9.3.7 The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.4 CONFLICT MANAGEMENT PROCESS

9.4.1 When there is a conflict between the Medical Staff and the Medical Executive Committee with respect to:

A. proposed amendments to the Medical Staff Rules and Regulations,

B. a new policy proposed by the Medical Executive Committee, or

C. proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

a special meeting to discuss the conflict may be called by a petition signed by at least 25% of the members of the Active Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

9.4.2 If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the members of the Active Staff, to the Board for final action.

9.4.3 This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.
SAINT FRANCIS HOSPITAL SOUTH

MEDICAL STAFF BYLAWS

CERTIFICATION OF ADOPTION AND APPROVAL

Revised and Adopted by the Medical Staff:

_________________________________________  ________________________________
Chief of Staff                                      Date
Saint Francis Hospital South

_________________________________________  ________________________________
Senior Vice President of Operations              Date
Saint Francis Hospital South

_________________________________________  ________________________________
Board of Directors, Saint Francis Health System  Date

Revised 9/03; 2/04; 1/05; 4/07, 02/11, 07/11, 02/12