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THE UNIVERSITY OF KANSAS HEALTH SYSTEM
Olathe Hospital

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Olathe Hospital Medical Staff Bylaws

MEDICAL STAFF BYLAWS

Revised: April 2025

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PREAMBLE

The following Bylaws of the Medical Staff of Olathe Hospital, which were developed and approved by the Medical Staff with subsequent approval by the Hospital Board, are provided for the organization and governance of the Medical Staff, Advanced Practice Providers, and Allied Health Professionals who are credentialed by the Medical Staff. These Bylaws provide the structure for Medical Staff, Advanced Practice Provider, and Allied Health Professional operations, organized Medical Staff relations with the Hospital Board, and relations with applicants to and Members of the Medical Staff, Advanced Practice Providers, and Allied Health Professionals. These Bylaws are adopted in recognition of the primary responsibility of individual Members of the Medical Staff for care of patients, the primary responsibility

of the Medical Staff as a whole to monitor the ethical and professional practices of Members and the exercise of Clinical Privileges within the Hospital, and the primary responsibility of the Board for oversight of Hospital administration and operations. These Bylaws are intended to provide reasonable notice of what is expected of Practitioners, Members of the Medical Staff, Advanced Practice Providers, and Allied Health Professionals granted Clinical Privileges, but may be supplemented by Rules and Regulations, Policies, and interpretations of the Hospital's Board of Directors upon recommendation of the Medical Executive Committee, as indicated and described herein.

DEFINITIONS

These definitions apply to all Medical Staff Documents.

ADVANCED PRACTICE PROVIDER or APP: A Licensed Practitioner other than a Physician (M.D. or D.O.), Dentist (D.D.S. or D.M.D.), or Podiatrist. An APP practices within the scope of their license and consistent with the Clinical Privileges granted by the Board. An APP may be credentialed pursuant to the Medical Staff Documents but is not eligible for Medical Staff Membership or entitled to certain rights granted to Medical Staff Members pursuant to these Bylaws. APPs currently approved to practice at the Hospital include Advanced Practice Registered Nurses (APRNs) (including certified nurse midwives, clinical nurse specialists, nurse practitioners, and certified registered nurse anesthetists), and Physician Assistants (PAs). Residents are not APPs.

ADVERSE ACTION: Means the following actions or recommendations:

A. Denial of an application for initial appointment to the Medical Staff or limitation of requested Clinical Privileges;

B. Denial of an application for reappointment to the Medical Staff or limitation of requested Clinical Privileges;

C. Denial of an application for modification of Clinical Privileges or limitation of requested Clinical Privileges;

D. Revocation of a Membership in the Medical Staff or any prerogative of said Membership in the Medical Staff;

E. Revocation of any portion of Clinical Privileges;

F. Recommendation for involuntary imposition of a mandatory concurrent consultation requirement that restricts the Practitioner's or APP's Privileges (i.e., based on the Practitioner's or APP's professional competence, the consultant or proctor must approve a course of treatment recommended by the Practitioner or APP's in advance, a proctor must be present and observe procedures, or a proctor may direct care or intervene with or stop a procedure) for a period in excess of thirty (30) days;

G. Suspension of Membership in the Medical Staff, or any prerogative of said Membership in the Medical Staff, if said suspension or limitation lasts or is scheduled to last for a period of greater than thirty (30) days; or

H. Suspension or limitation of any portion of existing Clinical Privileges, if said suspension or limitation lasts or is scheduled to last for a period of greater than thirty (30) days.

I. Summary suspension of Membership on the Medical Staff if the summary suspension lasts

for longer than thirty (30) days.

J. Limitation of the right to admit patients for more than thirty (30) days, unless based upon a reduction of Medical Staff category not related to an adverse determination as to a Practitioner's competence or professional conduct;

K. Immediate imposition of a mandatory proctoring requirement, for a period for more than thirty (30) days that restricts the individual's ability to exercise Privileges;

L. Immediate imposition of a mandatory concurrent consultation requirement for more than thirty (30) days that restricts Privileges (i.e., based on professional competence, the consultant or proctor must approve a course of treatment recommended by the individual in advance, a proctor must be present and observe procedures, or a proctor may direct care or intervene with or stop a procedure);

M. Suspension or revocation of all or some of a Practitioner's or APP's Temporary Privileges for more than thirty (30) days;

N. Recommendation to suspend or revoke all or some of a Practitioner's or APP's Temporary Privileges for more than thirty (30) days;

O. Recommendation to deny a Practitioner's or APP's request for reinstatement following a leave of absence; and/or

P. Any other Adverse Action that must by law be reported by the Hospital to the National Practitioner Data Bank, regardless of whether the Practitioner or any other individual or entity may have a separate reporting obligation.

ALLIED HEALTH PROFESSIONAL: An individual (other than a Physician (M.D. or D.O.), Dentist (D.D.S. or D.M.D.), Podiatrist (D.P.M.), or APP) who is appropriately licensed or trained to practice a health care profession and has been given permission by the Hospital to provide specific patient care services, under the supervision of, or at the request of, the Practitioner who is responsible for the patient's care or supervision of the AHP. AHPs are granted Clinical Privileges pursuant to these Bylaws and the Medical Staff Credentialing Policy. An AHP may be credentialed pursuant to these Bylaws and the Credentialing Policy but is not eligible for Medical Staff Membership or entitled to certain rights granted to Medical Staff Members pursuant to these Bylaws. AHPs are not considered to be practitioners for the purposes of compliance with The Joint Commission Standards for the accreditation and the Centers for Medicare & Medicaid Services ("CMS") Conditions of Participation for hospitals. AHP categories are defined in the Credentialing Policy.

APPEAL BODY: The panel composed of at least three (3) members of the Board or independent third parties designated or appointed by the Board to conduct the appellate review of a Hearing Panel's decision.

APPOINTMENT TERM: The period of time an individual has been appointed or reappointed to the Medical Staff or Allied Health Staff, never longer than thirty-six (36) months.

AUTOMATIC RELINQUISHMENT: a temporary discontinuation of Medical Staff Membership and/or one or more Clinical Privileges, as further set forth in Section 7.1 of these Bylaws, that is based on a threshold eligibility criteria or the application of an administrative rule outlined in the Medical Staff Documents, rather than being the result of a Peer Review action concerning the individual's clinical

competence or professional conduct. Automatic Relinquishment becomes effective upon Notice to the Practitioner and remains in effect until reinstatement is granted, if applicable, or until Automatic Termination occurs (and Notice of such Automatic Termination is provided to the Practitioner).

AUTOMATIC TERMINATION: The permanent termination of Medical Staff Membership and/or one or more Clinical Privileges that is based on the failure to resolve a matter that formed the basis for an Automatic Relinquishment within the required ninety (90) days period as set forth in Section 7.1 of these Bylaws, or that is based on the application of an administrative rule as outlined in the Medical Staff Documents. Automatic Termination becomes effective upon the expiration of the ninety (90) day period, or upon Special Notice to the Practitioner of the Automatic Termination and the administrative rule that formed the basis of the Automatic Termination. Membership and/or Clinical Privileges that have been Automatically Terminated are not eligible for reinstatement under Section 3.3 of these Bylaws. An application from Practitioner or APP who has had their Medical Staff Membership and/or Clinical Privileges Automatically Terminated shall be processed as an initial appointment in accordance with Section 3.2 of these Bylaws.

BOARD: The governing body or Board of Directors of the Hospital.

BOARD CERTIFICATION: Certification by a Specialty Board, recognized or certified by either the American Board of Medical Specialties, American Osteopathic Association or the American Board of Foot and Ankle Surgery, that an individual has successfully passed the examination and other criteria of the Specialty Board for such certification, and shall include, if appropriate, re-certification by the Specialty Board if the certification is time limited, unless the individual has been exempted by date of original certification, experience or otherwise by such Specialty Board.

BYLAWS: These Bylaws of the Medical Staff. This document together with the Credentialing Policy, Rules and Regulations, and Policies of the Medical Staff, as adopted by the Board, define the rights, responsibilities, and accountabilities of the Medical Staff and various officers, persons, and groups within the structure of the organized Medical Staff; the self-governance functions of the organized Medical Staff; and the working relationship with and accountability to the Board of the organized Medical Staff.

CAMPUS: The licensed facilities operated under the Hospital license.

CHIEF EXECUTIVE OFFICER: The individual appointed by the Board to act on its behalf in the overall administration and management of the Hospital.

CHIEF MEDICAL OFFICER: The physician who is a liaison between the Hospital and the Medical Staff. Responsibilities may be clinical or administrative in nature or both.

CHIEF OF STAFF: The chief elected officer of the Medical Staff or the Chief of Staff's designee. The Chief of Staff's designees shall include the Vice Chief of Staff, the Secretary/Treasurer, the immediate Past Chief of Staff, or if the listed designees are unavailable then other such Medical Staff Members designated by the Chief of Staff.

CHIEF OF SERVICE: The Medical Staff member duly appointed or elected in accordance with these Bylaws to serve as the head of a service.

CLINICAL PRIVILEGES or PRIVILEGES: Permission granted by the Board acting upon Medical Executive Committee recommendations, to Practitioners and APPs to provide specifically delineated diagnostic, therapeutic, medical, dental, podiatric, or surgical services to patients, with reasonable access to and use of Hospital equipment, facilities, and Hospital personnel necessary to effectively exercise such Privileges at Hospital facilities.

COMPLETED APPLICATION: An application for appointment or reappointment to the Medical Staff and/or grant of Clinical Privileges where all of the information required under the Bylaws, Rules and Regulations, other policies and procedures of the Medical Staff, and applicable privileges form is provided to the Medical Staff. The Medical Staff Office may consult with the Chief of Staff or their designee for any questions regarding a complete or incomplete application. If the required information is determined to be missing or incomplete by the Medical Staff Office, Chief of Service, Credentialing Committee, or Medical Executive Committee the application is considered incomplete. A Completed Application may be deemed incomplete at any time if the need arises for new, additional, or clarifying information in accordance with the Bylaws, Rules and Regulations, and other policies and procedures of the Medical Staff. .

CREDENTIALING: A Peer Review process that includes obtaining and verifying the contents of a completed initial application for Medical Staff Membership and Privileges or designation as an APP or AHP through the Medical Staff process. Re-Credentialing is the process of obtaining and verifying the contents of a completed reappointment application for Medical Staff Membership and Privileges, or designation through the Medical Staff process as an APP or AHP. Contents that were verified initially and are static, such as education, will not be re-verified.

DATE OF RECEIPT: The date any Notice, Special Notice or other communication was delivered personally or electronically; or if such Notice, Special Notice or communication was sent by mail, it shall mean seventy-two (72) hours after the Notice, Special Notice or communication was deposited, postage prepaid, in the United States mail. (See also, the definitions of "Notice" and "Special Notice" below).

DAYS: Unless otherwise indicated, calendar days. In calculating Days, the day after the act or event shall be considered the first day. The days shall be counted consecutively including Saturdays, Sundays, and legal holidays, unless specifically noted as "working days." If the last day falls on a Saturday, Sunday, or a legal holiday, the time period shall end on the next day that is not a Saturday, Sunday, or legal holiday, except as otherwise required by applicable law..

DENTIST: An individual who has received a Doctor of Dental Surgery or a Doctor of Dental Medicine degree and has a current, unrestricted license to practice dentistry in Kansas.

DISASTER PRIVILEGES: Those Clinical Privileges granted during a declared disaster as set forth in Section 4.5 of these Bylaws.

DISTANT-SITE: A Medicare-participating or Joint Commission accredited hospital or health care entity that furnishes Telemedicine services as a distant-site, such as a hospital, imaging center, urgent care center, medical practice, or independent medical provider.

EMERGENCY PRIVILEGES: Those Clinical Privileges granted to a Practitioner or APP to provide emergency treatment in order to save the life, limb, or organ of a patient as set forth in Section 4.4 of

these Bylaws.

ENCOUNTER: For the purposes of these Bylaws an "encounter" means any interaction between a Member and an outpatient or inpatient related to services provided by the Member at the Hospital, but not to include ordering of diagnostic tests and procedures.

EX OFFICIO: Service as member of a body or committee by virtue of an office or position held, and unless otherwise expressly provided, without voting rights.

FEDERAL HEALTHCARE PROGRAM: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program. The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program/Tricare/Champus and the Veterans programs.

FEDERATION OF STATE MEDICAL BOARDS: Physician Data Center that provides sanctions reported by state licensing boards, the Department of Health and Human Services, and federal regulatory agencies.

FOCUSED PROFESSIONAL PRACTICE EVALUATION or FPPE: The time-limited evaluation of a Practitioner's or APP's competence in performing a specific Privileges.

GOOD STANDING: The term describes a Medical Staff Member who, during the current appointment term, has maintained qualifications for Medical Staff Membership and assigned staff category, has met any required meeting attendance and Medical Staff participation requirements, is not in arrears in the completion of medical records or other requirements of Medical Staff Membership, and has not received a recommendation for or a suspension or restriction of Membership or Privileges.

HEARING PANEL: The individuals designated or appointed to conduct a review of an Adverse Action against a Practitioner upon submission a timely request for a Hearing as set forth in Article 8 of these Bylaws.

HOSPITAL: Olathe Hospital including all facilities, services, and locations owned and operated by, licensed, accredited as part of the Hospital.

INVESTIGATION or FORMAL INVESTIGATION: The Peer Review process of gathering and reviewing information related to a concern regarding the competence, professional conduct, or quality and appropriateness of care provided by a Licensed Independent Practitioner or APP, which is undertaken after approval by the Medical Executive Committee or Board to initiate an Investigation.

INVESTIGATING BODY: The individual, or standing or ad hoc committee, including the Medical Executive Committee, designated or appointed to conduct an Investigation.

LICENSED PRACTITIONER: An individual who is permitted by the state of Kansas and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license, documented professional competence, and in accordance with individually granted Clinical Privileges.

MATERIAL MISREPRESENTATION: A misrepresentation or omission on an application which, if known to the Medical Staff committee, Medical Staff Officer or other Medical Staff leader, may have altered the Credentialing or Privileging review process or outcome.

MATERIAL NOTIFICATION EVENT: Any occurrence or change in a Practitioner's, APP's, or AHP's status that could potentially impact the individual's Membership or Clinical Privileges as further set forth in Section 1.5(B) of these Bylaws.

MEDICAL EXECUTIVE COMMITTEE: The Committee established pursuant to these Bylaws to act on behalf of the Medical Staff and to perform other functions specified by the Medical Staff Documents.

MEDICAL SCHOOL: The University of Kansas Medical Center School of Medicine.

MEDICAL STAFF or STAFF: The self-governing body, accountable to the Board, that operates under these Bylaws and the Medical Staff Documents. The Medical Staff is composed of Practitioners, recommended by the Medical Staff (through the Medical Executive Committee) and approved by the Board.

MEDICAL STAFF DOCUMENTS: Collectively the Medical Staff Bylaws, the Credentialing Policy, the Rules and Regulations, and the Policies of the Medical Staff.

MEDICAL STAFF OFFICE: The Hospital's Section that provides administrative and technical support for the Medical Staff. All notices to or from the Medical Executive Committee, or other Medical Staff committees may be submitted to or by the Medical Staff Office on behalf of the committee.

MEDICAL STAFF YEAR: The period from July 1 through June 30.

MEMBER: An individual who has been granted and maintains Medical Staff Membership pursuant to the Medical Staff Bylaws.

MEMBERSHIP: The approval granted by the Board to a qualified individual to be a member of the Medical Staff of the Hospital.

NOTICE: A written communication delivered personally to the addressee or sent by United States mail, postage prepaid, or by facsimile or by electronic transmission addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital.

ONGOING PROFESSIONAL PRACTICE EVALUATION or OPPE: The summary of routine and ongoing data collected for the purpose of assessing a Practitioner's or APP's clinical competence and professional behavior. The information gathered during the OPPE process is factored into decisions to maintain, revise, or revoke existing Clinical Privilege(s) prior to or at the end of the three-year Privilege renewal cycle.

PEER: A qualified health care provider of similar training or experience who can render an informed opinion on the competence or quality of patient care, treatment, or services delivered by a Practitioner, Licensed Practitioner, or APP.

PEER REVIEW: The entire process to evaluate the competence, professional conduct, or the quality and appropriateness of care provided by Practitioners and APPs, including without limitation Credentialing, Privileging, Focused Professional Practice Evaluation (FPPE), Ongoing Professional Practice Evaluation (OPPE), Investigation, and actions relating to the authorization to provide patient care in the Hospital, and any other actions or functions as set forth under applicable Kansas law including without limitation K.S.A. § 65-4915 and § 65-4921 et seq.

PHYSICIAN: An individual who has been educated and trained in the practice of medicine and who holds a current license in Kansas to practice as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

PODIATRIST: An individual who has been educated and trained in the practice of podiatric medicine and holds a current license in Kansas to practice as a Doctor of Podiatry.

POLICIES: Any policies or procedures of the Medical Staff, collectively.

PRACTITIONER: Unless otherwise expressly limited, any currently licensed Physician (M.D. or D.O.), Dentist (D.D.S. or D. M.D.), or Podiatrist (D.P.M.).

PRIVILEGING: A Peer Review process that includes evaluating and assessing the initial request for Privileges or the request for modification of Privileges for Practitioners and APPs through the Medical Staff process. Re-Privileging is the process of re-evaluating and re-assessing the request for Privileges for Practitioners and APPs through the Medical Staff process at reappointment.

PROCTORING: The focused observation and supervision of a Practitioner or APP to evaluate and confirm the Practitioner's or APP's current competence either at the time new Clinical Privileges are granted, whether at initial granting of Medical Staff Membership or Clinical Privileges or in connection with a request for new or expanded Clinical Privileges by a current Member or APP, or when a question arises regarding a currently privileged Practitioner's or APP's ability to provide safe, effective, high quality patient care.

REGISTRATION: The process by which an individual, who is licensed to practice by a federal or state authority, has such license recorded or registered.

RESIDENT: An intern, resident or fellow participating in an approved Graduate Medical Education program approved by the Hospital.

RESIGNATION: The permanent discontinuation of Medical Staff Membership and/or one or more Clinical Privileges that results from the Practitioner's affirmative request to resign as outlined in Sections 1.8 of these Bylaws, or from the Practitioner's otherwise expressed intention to abandon, terminate, discontinue, surrender, relinquish, or resign Membership and/or Clinical Privileges. Resignation becomes effective upon Notice to the Practitioner that a request for Resignation has been granted (or upon the date of Resignation specified in the Notice). Membership and/or Clinical Privileges that have been Resigned are not eligible for reinstatement under Section 3.3 of these Bylaws. An application from Practitioner or APP who has resigned their Medical Staff Membership and/or Clinical Privileges shall be processed as an initial appointment in accordance with Section 3.2 of these Bylaws.

RULES AND REGULATIONS: The Rules and Regulations of the Medical Staff, including those of its Services, as approved by the Medical Executive Committee and the Board. When adopted by the organized Medial Staff, pursuant to the Bylaws and approved by the Board, these documents have the force and effect of the Medical Staff Bylaws.

SENIOR VICE PRESIDENT or SVP: The Senior Vice President of Clinical Affairs of the Health System.

SERVICE: A group of Practitioners who hold Clinical Privileges in any one of the general areas of medicine, surgery or obstetrics/pediatrics.

SPECIAL NOTICE: A Notice delivered personally to the addressee or sent by certified or registered mail, return receipt requested, or if there is any impediment to the U.S. Postal Service, the Chief Executive Officer, Chief of Staff, or their designees, in their discretion, may have Special Notice delivered by electronic transmission addressed to the addressee at the last email address provided to the Medical Staff Office.

SUBSTANTIAL COMPLIANCE: With respect to these Bylaws, means reasonable, good faith, efforts to comply with the provisions of the Medical Staff Documents. Technical or minor procedural deviations from the procedures set forth within the Medical Staff Documents do not invalidate the recommendations, reviews, or actions of the Hospital, Board, Administration, or Medical Staff.

TELEMEDICINE SERVICES: The provision of clinical services to patients by Practitioners or APPs from a distance via electronic communication including but not limited to telemedicine and telehealth services.

TEMPORARY PRIVILEGES: Clinical Privileges granted to a Practitioner, APP, or AHP for a specified period of time, not to exceed one ninety (90) days, and under prescribed circumstances as set forth in Section 4.3.

VICE CHIEF OF STAFF: The elected successor to the Chief of Staff of the Medical Staff or the Chief of Staff-Elect's designee.

ARTICLE 1: PURPOSES AND MEMBERSHIP

1.1 GENERAL PURPOSE

The purposes of the organized, self-governing Medical Staff are to organize Physicians, Dentists, and Podiatrists who hold appointment and/or Clinical Privileges at the Hospital into a cohesive body to promote the provision of patient care within acceptable standards, to monitor and evaluate patient satisfaction, the quality of professional services provided by Members and those individuals granted Clinical Privileges, and to offer advice, recommendations and input to the Chief Executive Officer and the Board. These Bylaws, which are developed, adopted and amended by the Medical Staff or such functions delegated to the Medical Executive Committee by the Medical Staff, subject to approval of the Board, have the following purposes: to outline the expectations of Medical Staff Membership, describe the operating procedures for the Medical Staff, Advanced Practice Providers, and Allied Health Professionals, and explain the relationship of the Medical Staff to the Hospital.

1.2. TIME PERIODS AS GUIDELINES

The time periods in these Bylaws are guidelines and are not directives that create any rights for a Practitioner, APP, or AHP to have an application processed, Investigation completed, or any other action taken within these precise periods, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.3. QUALIFICATIONS FOR MEMBERSHIP AND CLINICAL PRIVILEGES

A. General

1. Only Physicians, Dentists, and Podiatrists who satisfy the threshold criteria detailed in this Section or as otherwise provided in the Medical Staff Documents, shall be eligible for consideration for Medical Staff Membership and/or the grant of Clinical Privileges. The Hospital shall utilize a specialized process, approved by the Medical Executive Committee and the Board, to evaluate whether an individual seeking Medical Staff appointment, reappointment or the grant of Clinical Privileges satisfies these eligibility requirements.
2. The due process rights detailed in Article 8 are not available when, because of ineligibility, any applicant's request for a medical staff application form is declined or an application form is returned to any applicant on this basis or as otherwise provided in the Medical Staff Documents.

B. Qualifications

The following qualifications are those minimally required for Medical Staff Membership and/or the grant of Clinical Privileges and shall be considered threshold criteria for Medical Staff Membership and/or the grant of Clinical Privileges:

1. Demonstrate proof of graduation from an accredited School of Medicine, Dentistry or Podiatry. All Foreign medical graduates must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification from a foreign medical school and demonstrate proof of United States citizenship or a valid visa or work permit.
2. Demonstrate certification by a professional board recognized by the American Board of Medical Specialties, the American Osteopathic Association or the American Board of Foot and Ankle Surgery, in the area of practice appropriate to the Clinical Privileges requested unless otherwise approved by the Hospital Board of Directors. Board certification and residency training must be completed in the area(s) of proposed practice and Clinical Privileges. Current medical staff members are required to maintain board certification in which they currently practice and hold privileges in.
    a. Specialty board certification must be obtained by the end of the fifth (5th) year after first becoming eligible to sit for the certifying examination. Should the Medical Staff Member lose qualifications to be able to sit for the examination during the five (5) years from which the Member was appointed to the Medical Staff, the Member is no longer eligible for Medical Staff Membership and Clinical Privileges. In such case, Membership and Clinical Privileges would be considered automatically withdrawn upon the date it becomes known that the Medical Staff Member is no longer qualified to sit for the specialty Board certification examination. Failure to maintain certification shall result in automatic referral to the Medical Executive Committee for review of Clinical Privileges and Membership.

b. Current Members of the Medical Staff who completed training prior to May 21, 1985 and are unable to demonstrate proof of recognized specialty board certification or eligibility, shall be permitted to apply for Medical Staff reappointment as appropriate, provided all other threshold qualifications for Medical Staff Membership are demonstrated.

c. Exceptions regarding Board certification shall be reviewed and recommended by the Medical Executive Committee and approved by the Board of Directors. The Board has discretion to waive the board certification requirement following receipt of a recommendation from the Medical Executive Committee in accordance with Section 1.4 below.

3. If the applicable specialty board eligibility requirements do not include the successful completion of a residency program within that specialty, the applicant must demonstrate proof of completion of an approved post-graduate training program. All dentist applicants must have successfully completed an approved post-graduate training program.

    a. For purposes of this Section, an "approved" postgraduate training program for physicians is a residency program fully accredited throughout the time period of training by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association or an equivalent organization in a country for which eligibility for licensure by endorsement is available by the Kansas Board of Healing Arts. An approved post-graduate training program for podiatrists is one fully accredited throughout the time period of training by the Council on Podiatric Medicine, the American Podiatric Medical Association, a successor agency to either of the foregoing, or by an equivalent professionally recognized national accrediting body in the United States or in a country for which eligibility for licensure by endorsement is available by the Kansas Board of Healing Arts. An approved post-graduate training program for dentists is one fully accredited throughout the time period of training by the Commission on Dental Accreditation, a successor agency to either of the foregoing, or by an equivalent professionally recognized national accrediting body in the United States or in a country for which eligibility for licensure by endorsement is available by the Kansas Board of Healing Arts.

4. Demonstrate proof of a currently unrestricted license to practice their profession by the Kansas Board of Healing Arts. For purposes of this Section, an unrestricted license is one free of any formal disciplinary restrictions instituted by the Kansas Board of Healing Arts (BOHA) as follows: probation; suspension; or, requirements of special supervision, consultation or proctoring, except when the disciplinary restriction instituted by the BOHA is based solely on a physician's impairment. The term "impairment" includes physical or mental disabilities, including deterioration through the aging process, loss of motor skills or abuse of drugs or alcohol. Pursuant to Kansas law, an impaired physician who is participating in or has successfully completed a treatment program shall not be ineligible for or denied appointment or Clinical Privileges based solely on the existence of the impairment;

however, the impairment may be considered in determining the extent of privileges granted. Verification of a licensure will occur at the time of initial granting, renewal, and revision of privileges, at the time of licensure expiration as appropriate.

5. Demonstrate participation in all federal health care programs, as defined in the Medical Staff Bylaws. Those ineligible to participate, voluntarily not participating (opting out), excluded, suspended or disbarred from participation in such programs, or those convicted of a criminal offense related to the provision of health care items or services whose eligibility to participate in such program has not been reinstated are ineligible for Medical Staff Membership and/or Clinical Privileges.
6. Document one's background, education, experience, training and demonstrated current clinical competence, adherence to the ethics of one's profession, good reputation and character, current physical and mental health as such relates to the ability to safely and competently perform the requested Clinical Privileges with or without reasonable accommodation, and the ability to work harmoniously with peers, Hospital employees, and others sufficiently to evidence that all patients treated at the Hospital shall receive quality care.
7. For current Medical Staff members, evidence of current competence, experience and judgment shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement, risk management and peer review activities, consideration of the applicant's compliance with the responsibilities of Medical Staff Membership during the previous term(s) of appointment, and recommendations of the Chief of Service. For current Medical Staff members, evidence of the ability to work harmoniously with others shall include, but not be limited to, a review of the applicant's conduct and compliance with the responsibilities of Medical Staff Membership during the previous term(s) of appointment, and recommendations of the Chief of Service.
8. Document compliance with Section 1.3(D) regarding professional liability insurance and demonstrate proof of and agree to maintain professional liability insurance coverage in the minimum amount of $1 million per occurrence/$3 million aggregate, which includes Kansas Health Care Stabilization Fund coverage, as applicable. If not statutorily required to participate in the Kansas Health Care Stabilization Fund, the individual agrees to maintain professional liability insurance coverage in the minimum amount of $1 million per occurrence/$3 million aggregate.
9. Provide evidence of and agree to maintain a current, valid Federal Drug Enforcement Administration registration (DEA certificate) and Kansas prescribing authority for controlled substances (as appropriate to the intended scope of practice).
10. For all new applicants, reappointment and additional privilege applicants, demonstrate there is no pending recommendation at another health care facility to suspend, revoke or otherwise restrict Medical Staff Membership or Clinical Privileges, including any summary or precautionary suspension.
11. Agree to participate in and properly discharge Medical Staff responsibilities and assist the Medical Staff to fulfill its obligations related to patient care within the areas of their professional competence and credentials.
12. Have never been convicted of, or entered a plea of guilty or nolo contendere to, any

felony under federal or state law; or convicted of, or entered a plea of guilty or *nolo contendere* to, any healthcare-related misdemeanor under federal or state law.

C. Effect of Prior Adverse Professional Review Action

1. Except as otherwise determined by the Medical Executive Committee and approved by the Board in light of special circumstances, a Member who has received a final adverse professional review action or voluntarily resigned appointment/privileges during the pendency of a professional review activity, shall not be eligible to reapply for appointment or, as applicable, for those Clinical Privileges which were the subject of the professional review action or professional review activity for a period of three (3) years from the date of the notice of the final adverse decision or the date of the voluntary resignation. When such individual is eligible to apply, the application shall be processed as an initial appointment in accordance with Article 3.

D. The Hospital Professional Liability Insurance Requirement

1. All Members of the Medical Staff who are health care providers as defined by K.S.A. § 40-3401, as amended, shall maintain the minimum level of coverage under the Kansas Health Care Stabilization Fund.
2. Members of the Medical Staff are required to maintain professional liability insurance protections to cover the term of their appointment/privileges, including tail coverage as appropriate, by an insurance company that is licensed or authorized to conduct business in Kansas. Member must be able to show proof of tail coverage upon request.
3. If a Medical Staff Member changes professional liability insurance carriers for any reason or has insurance coverage limited or terminated for any reason, the Medical Staff Member shall immediately notify the Medical Staff Office of such event.

1.4. WAIVER OF QUALIFICATION CRITERIA

A. The Board has the discretion to deem a Practitioner to have satisfied a threshold qualification criteria for Medical Staff Membership, assignment to a particular staff category, or delineation of a Clinical Privilege, as applicable, except as required by law and only as it relates to the specified areas of Privileges or Membership.

B. An applicant wishing to request a waiver of the threshold qualification criteria must submit a written request together with any additional evidence or documentation supporting the requested waiver to the Medical Staff Office within thirty (30) days of receipt of Notice that the applicant failed to meet the threshold qualification criteria.

C. The Board has discretion to waive the qualification, following receipt of recommendations from the Credentials Committee and Medical Executive Committee, if the Board determines:

1. The Practitioner has demonstrated by clear and convincing evidence that the Practitioner has substantially comparable qualifications;
2. Waiving the qualification is not inconsistent with applicable laws and accreditation standards;
3. Waiving the qualification is necessary to serve the best interests of the patients and the Hospital; and

4. Waiving the qualification fulfills an important patient care, treatment, or service need.

D. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws. A determination to grant a waiver does not mean that Membership or Clinical Privileges will be granted; only that the applicant's application can be processed further.

E. The waiver, if granted, may set a waiver period and any additional conditions associated with such waiver. If the waiver is granted and the Practitioner does not meet any of the conditions associated with the waiver by any time period or deadline, then Practitioner's Privileges shall be automatically relinquished as of the date the Practitioner fails to meet such condition(s).

1.5. RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

A. By submitting an application for Medical Staff appointment, reappointment or Clinical Privileges, the applicant agrees to fulfill the following responsibilities:

1. supplement the applicant's application with additional information as requested by the Medical Staff Office, Chief of Service, Credentials Committee, Medical Executive Committee and/or Board of Directors and appear for any requested interviews regarding their application, or, subsequent to appointment, reappointment or the grant of Clinical Privileges, appear for any requested interviews related to questions regarding the applicant's competence or performance within thirty (30) days of the applicant's receipt of the request;
2. provide continuous care and supervision to the applicant's patients at the generally recognized professional level of quality and efficiency established by the Hospital and respond to their needs within a reasonable time period under the circumstances or as otherwise specified in these Bylaws, and the Medical Staff Documents;
3. as the attending physician, coordinate care, treatment, and services among all consultants involved in a patient's care and treatment;
4. comply with Hospital policies related to informed consent and patient rights as more fully described in the applicable Hospital policies and the Medical Staff Rules and Regulations;
5. delegate, in the applicant's absence, the responsibility for diagnosis and/or care of the applicant's patients only to a Member in good standing of the Medical Staff who is qualified and approved by the Hospital to undertake this responsibility by the grant of similar Clinical Privileges;
6. seek consultation whenever necessary, and in accordance with the requirements of the Medical Staff Rules and Regulations and policies of the Hospital;
7. accept and respond to consult requests in the manner and time period consistent with the Medical Staff Documents;
8. work cooperatively and professionally with Members, Hospital staff, Hospital Administration and others so as not to adversely affect the delivery of patient care;

9. refuse to engage in fee splitting or improper inducements to obtain patient referrals;
10. abide by the Medical Staff Documents, the Hospital Corporate Compliance Plan, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital;
11. regularly attend assigned Committee meetings unless excused;
12. discharge such Medical Staff, Service, Committee, and Hospital functions for which the applicant is responsible based upon appointment, election, medical staff category or otherwise, including as appropriate, providing on-call coverage for the Emergency Department within the applicant's clinical specialty, accepting Committee assignments, and participating in performance improvement, peer review and risk management activities;
13. participate in any necessary training regarding the electronic medical record and document completely, timely, legibly, and accurately in medical records as specifically required by the Medical Staff Rules and Regulation, in all other documents related to care provided in the Hospital, and to similarly comply in all verbal and written communications with Hospital representatives and Medical Staff Committees and representatives. Dishonesty or misrepresentations in any such document, record, or communication may be a basis for termination of Medical Staff Membership and Clinical Privileges, or other action as provided by the Medical Staff Documents, or in policies and procedures as adopted by the Board from time to time;
14. refrain from transferring any patient from the Hospital unless such transfer is in the patient's best interest and accomplished in compliance with all applicable statutes, regulations and Hospital policies;
15. cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;
16. participate in continuing education to maintain clinical skills and current competence;
17. notify, immediately (and in event later than five (5) business days after being provided notice of the change), the Chief of Staff or the Medical Staff Office of a change, modification, or update set forth in Section 1.5(B). ;
18. upon request by the Medical Executive Committee, the Board, or the Practitioner Health Committee, submit evidence of physical and/or mental health sufficient to fulfill these responsibilities of Medical Staff Membership and permit the safe performance of the Clinical Privileges granted to the Member;
19. promptly notify and update the Practitioner Health Committee, through the Chairman of the Practitioner Health Committee, of any change in the Member's health status which could adversely impact the Member's ability to safely carry out the requested or, in the case of a Member, granted privileges;
20. appear, if requested, for personal interviews regarding any question on the application for medical staff appointment, reappointment, additional privilege or Clinical Privileges;

21. pay any medical staff dues when required by Medical Staff policy and in accordance with the requirements of the Medical Staff Documents; and
22. perform such other responsibilities as the Hospital or the Medical Staff may require.

B. Ongoing Obligation to Update Initial Appointment and Reappointment Applications

1. All current Members and all applicants for appointment and reappointment or for Clinical Privileges following completion of an application and continuing so long as such Member or APP is appointed to the Medical Staff and/or maintains Clinical Privileges at the Hospital, shall have the obligation to immediately notify, within five (5) business days or less, the Chief of Staff, or the Chief of Staff's designee, upon becoming aware of any of the following:
    a. Notice of the initiation of any action and/or the taking of any final action by any federal or state regulatory agency which may result in any changes to the member's professional licensure or ability to prescribe controlled substances in any jurisdiction including without limitation the revocation, suspension, or imposition of probation or limitations on the applicant's license;
    b. Notice of the initiation of any action, investigation, or proceeding, including any hearing or appeal process, and/or the taking of any final action by any hospital, health maintenance organization, health plan, health insurance company or other health care entity, including any state or federal government agency, which may result in the denial, limitation, revocation, or involuntary withdrawal or surrender of the member's medical staff privileges, provider status or other membership in such hospital, health plan, health insurance company or other health care entity, including Medicare, Medicaid or any other Federal Healthcare Program;
    c. Notice of any formal charges or commencement of a formal investigation by any professional regulatory agency, HHS, peer review organization, or law enforcement or health regulatory agency, including without limitation any formal charge or investigation by the applicable professional licensing board related to the individual's professional licensure or the provision of health care services;
    d. The Member's voluntary withdrawal or surrender of, or change or limitation in, the licensure, registrations, staff privileges, provider status or memberships while under investigation or to avoid investigation or other Peer Review activity by any health entity or by any federal or state regulatory agency;
    e. The initiation, settlement, adjudication or other resolution of any claim or lawsuit in any jurisdiction in which the member has been accused of a breach of the standard of care resulting in injury to a patient;
    f. The onset or recurrence of any physical or mental illness, injury, disorder, or condition (including chemical dependency or substance abuse) that affects the member's ability to properly render medical care to patients, with or without accommodation or assistance, or causes the member to undergo major surgery, extended treatment or rehabilitation, or to refrain

from exercising the member's Clinical Privileges for an extended period of time;

g. Any criminal complaint, criminal information or charge, criminal indictment, criminal conviction, no contest plea, guilty plea, or criminal offense except for misdemeanor offenses punishable only by a fine unless such misdemeanor offence involves (a) insurance or health care fraud or abuse, (b) violence, physical abuse, or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs;

h. Any claim, judgment, or settlement filed against the Member's professional liability insurance; and

i. Any modification to or termination of the Member's professional liability insurance, other than a change of carrier.

2. Additionally, all members shall notify the Chief of Staff, or the Chief of Staff's designee, within thirty (30) days of any change, modification or update to any other information which the member provided in the Application that would not be considered a Material Notification Event.

C. Failure to Report Information

1. Failure to notify, immediately (and in no event later than five (5) business days after being provided notice of the change), the Chief of Staff or Medical Staff Office of a change, modification, or update set forth in Subsection 1.5(B) above will result in the automatic relinquishment of Membership and Clinical Privileges, as applicable, or for applicant's the automatic withdrawal of the application. This provision shall not apply to failure to report the filing of a claim against the Member alleging professional liability.

2. Following the imposition of Automatic Relinquishment, a Member, APP, or AHP may request reinstatement. The Member, APP, or AHP requesting reinstatement bears the burden of demonstrating that the matter leading to Automatic Relinquishment has been resolved. Requests for reinstatement from an Automatic Relinquishment will be reviewed by the relevant section chief, Credentials Committee Chair, the Chief of Staff, the Chief Medical Officer, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Member, APP, or AHP may immediately resume clinical practice at the Hospital. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted, and the reinstatement request will be forwarded to the full Credentials Committee, Executive Committee of the Medical Staff, and Board for review and vote.

3. Failure to resolve the matter leading to the Automatic Relinquishment, provide notice to Medical Staff Office of the resolution, provide any additional requested information, and be reinstated within ninety (90) days of a relinquishment will result in an automatic resignation from the Medical Staff and resignation of all Clinical Privileges.

D. Fitness For Practice Evaluation

1. A Practitioner may be requested to submit (immediately or within the timeframe

otherwise designated by the requestor) to a partial or complete fitness for practice evaluation to determine the Practitioner's ability to safely practice and competently exercise Clinical Privileges.

2. A request for an evaluation may be made as follows:
    a. of an applicant, by the Credentials Committee or Medical Executive Committee;
    b. of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by the Investigating Body, during an Investigation;
    c. of any Practitioner who is requesting reinstatement from a leave of absence that was taken for health reasons;
    d. of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by any one of the following groups, if the group is concerned with the individual's current clinical competence or ability to safely care for patients:
        i. at least two (2) Medical Staff leaders;
        ii. one Medical Staff leader and one member of the Hospital administration;
        iii. any Hospital or Medical Staff committee that conducts credentialing, Peer Review, or Professional Practice Evaluation activities; or
        iv. the Board.

3. The Medical Staff leaders or committee that requests the evaluation will: (i) identify the health care professional(s) or organization(s) to perform the evaluation; (ii) inform the Practitioner of the time period within which the evaluation must occur (which may be immediate, if the individual or committee making the request deem it appropriate, such as in the case where impairment is suspected); and (iii) provide the Practitioner with all appropriate releases or authorizations to allow the Medical Staff leaders or relevant committee, to discuss with the health care professional or organization performing the evaluation the reasons for the evaluation and to allow the health care professional or organization to discuss and report the results to the Medical Staff leaders or relevant committee.
4. The Practitioner is required to execute any releases or authorizations that are requested by the Medical Staff Leader or committee as well as any releases or authorizations required by the individual or program conducting the evaluation, in order to: (i) authorize the relevant Medical Staff leaders and committees to discuss the reasons for the evaluation with the individual or organization performing the evaluation, and (ii) authorize the individual or organization to discuss and release the results of the evaluation to the Medical Staff leaders or relevant committees.
5. Failure to obtain the requested evaluation or to execute the appropriate releases and authorizations, and to do so within the required time frame, will, upon Notice to the individual, result in the Application being deemed withdrawn for an applicant or, for a Member or Practitioner granted Clinical Privileges, result in the Automatic Relinquishment of Membership and Clinical Privileges as set forth in these Bylaws.

1.6. NONDISCRIMINATION

The Hospital will not discriminate in granting appointment and/or Clinical Privileges on the basis of ancestry, race, creed, national origin, gender, faith, age, sexual preference or orientation, disability, or veteran status.

1.7. NATURE OF MEDICAL STAFF MEMBERSHIP

A. The responsibilities of Medical Staff Membership, and the specific requirements and procedures for appointment and reappointment to the Medical Staff, the granting of Clinical Privileges, and procedures for corrective action are as set forth in these Bylaws, Rules and Regulations and Medical Staff policies/procedures.

B. The Medical Staff includes Physicians, Dentists and Podiatrists licensed and in good standing under Kansas law to provide patient care independently within the Hospital who are appointed by the Board.

C. A Medical Staff Member is neither an employee nor an independent contractor of the Hospital, unless such relationship is separately established by contract between the Hospital and the Member. In the event of any conflict between such contract and these Bylaws, the language in the contract shall apply.

D. No Member shall admit patients or provide services to Hospital patients unless the Member is appointed to the Medical Staff and has been granted Clinical Privileges in accordance with the Medical Staff Bylaws.

    1. Medical Staff Membership is a privilege extended by the Hospital and is not a right or entitlement of any Physician, Dentist or Podiatrist.
    2. Medical Staff Membership and/or the permission to exercise Clinical Privileges are extended only to individuals who continuously meet the requirements of the Medical Staff Documents.

E. Appointment to the Medical Staff or the grant of Clinical Privileges shall confer on the individual only such prerogatives of Membership that are granted by the Board based on its approval of the individual's Medical Staff category or as are afforded to Advanced Practice Providers when Clinical Privileges are granted to an individual in this category.

    1. The grant of Membership or approval of appointment does not automatically confer Clinical Privileges.
    2. An individual may be a Member of the Medical Staff without holding Clinical Privileges.
    3. The grant of Clinical Privileges does not automatically confer Medical Staff Membership or appointment.
    4. An individual may be granted Clinical Privileges without Medical Staff Membership or appointment, as in the case of an Allied Health Professional.
    5. The Board has determined the categories of healthcare professionals eligible for Medical Staff Membership and/or Clinical Privileges, as defined in these Bylaws.

F. No one shall be eligible for or entitled to maintain Medical Staff Membership where the

commitments and affiliations, the practice patterns, or the acts or omissions of any such individual may, in the judgment of the Board, be inconsistent with the objectives or efficient operations of the Hospital, reduce the Hospital's standards of patient care, be inconsistent with patient welfare, be in violation of the policies and procedures of the Hospital, the Rules and Regulations of the Medical Staff or of the Medical Staff Documents, constitute misconduct in the Hospital, or reflect a lack of sufficient character or competency.

G. The qualifications and considerations set forth in these Bylaws and the Medical Staff Documents are not intended to be exclusive. All other factors reasonably related to the qualifications of an individual to exercise the privileges requested or relative to reasonable objectives of the Hospital may also be considered. In addition, further qualifications, considerations and procedures for appointment and Clinical Privileges shall be as provided in the Medical Staff Documents, and in policies and procedures adopted by the Board from time to time. The procedures specified herein shall not preclude the Board from taking any direct action or utilizing other methods for addressing disruptive or other unacceptable conduct.

1.8. RESIGNATION

A. Resignations from the Medical Staff shall be submitted in writing to the Medical Staff Office and shall state the date the resignation becomes effective. The resignation shall be accepted as in "good standing" provided all incomplete medical records and any open Medical Staff and Hospital matters have been concluded. The Member's Chief of Service, the Medical Executive Committee, and the Board shall review letters of resignation and determine if such acceptance is made when possible.

B. Once submitted, a resignation may not be withdrawn until it has been considered by the Board. If a Member requests to withdraw a resignation before the resignation is accepted by the Board, the request for withdrawal shall also be forwarded to the Board for consideration. The Board may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board, the Member shall be notified in writing.

C. When a Medical Staff resignation is accepted or Clinical Privileges are relinquished during the course of a professional review activity related to issues of clinical competency or professional conduct, a report shall be submitted to the Kansas Board of Healing Arts and the National Practitioner Data Bank, as required by law.

D. Resignation of Medical Staff Membership and/or Clinical Privileges does not prohibit a Practitioner from submitting an application for initial appointment or for new Medical Staff Membership or Clinical Privileges, which will be reviewed in accordance with Section 3.2 of these Bylaws and the Medical Staff Documents.

1.9. EFFECT OF OTHER AFFILIATIONS

No person will be entitled to Membership on the Medical Staff solely because they hold a certain degree, is licensed to practice in this or any other state, is a Member of any professional organization, is certified by any Specialty Board, or has been granted Medical Staff Membership or privileges at another hospital.

1.10. HOSPITAL NEED

No individual shall be appointed or reappointed to the Medical Staff or granted Clinical Privileges if the

Hospital is unable to provide adequate facilities and support services for the applicant or the applicant's patients. The Board may decline to accept and/or, through the Credentials and Medical Executive Committees, decline, to process applications and recommend applicants for Medical Staff appointment, reappointment, and/or Clinical Privileges based on any of the following.

A. **Lack of Facilities/Support Services**
Clinical privileges shall be granted only for the provision of care that is consistent with the scope of services, capacity, capabilities, and business plan of the Hospital.

B. **Exclusivity, Employment and Professional Services Agreements**

1. *General*
The Hospital shall not automatically confer appointment or reappointment and/or grant Clinical Privileges based on an individual's inclusion or consideration for inclusion in an exclusivity, employment or professional services agreement. Instead, each individual shall be considered for appointment, reappointment and/or Clinical Privileges based on whether the individual meets the qualifications for Medical Staff Membership and whose education, training, experience and demonstrated current competence are sufficient, in the opinion of the Board as recommended by the Medical Executive Committee, to obtain the requested Clinical Privileges. Once appointed, reappointed and/or granted Clinical Privileges, the Member who is a party to any such agreement shall comply with the Medical Staff Documents, and the Hospital's Corporate Compliance Plan and Policies/Procedures to maintain such appointment, reappointment and Clinical Privileges.

The effect of expiration or other termination of an agreement upon a Member's Medical Staff appointment, reappointment and/or Clinical Privileges shall be governed by the Medical Staff Documents unless the Member's agreement with the Hospital addresses the issue, in which case the terms of the agreement shall be given full force and effect. If the agreement is silent on the matter, then expiration of the agreement or other termination alone shall not affect the Member's appointment, reappointment and/or Clinical Privileges, except that any Member who is a party to an expired or terminated exclusivity agreement may not thereafter exercise any Clinical Privileges for which exclusive contractual arrangements have been made with others.

Unless the agreement provides otherwise, a Member whose employment or professional services agreement is terminated for cause related to the Member's professional competence or conduct, shall be entitled to the procedural rights afforded in Article 8, as to the Member's appointment, reappointment and/or Clinical Privileges. A Member whose agreement expires in accordance with its terms and is not renewed is not entitled to the procedural rights provided in Article 8 unless the agreement provides otherwise.

2. *Exclusivity Agreements*
Pursuant to Kansas law, the Board may determine, in the interest of quality patient care, efficient hospital operations, and as a matter of policy, that certain Hospital clinical facilities may be used only on an exclusive basis in accordance with written agreements between the Hospital and qualified Medical Staff members. Accordingly,

the Hospital shall not accept applications for appointment, reappointment or Clinical Privileges which relate solely to facilities or services covered by exclusivity agreements, unless the applicant qualifies under the existing agreement.

C. **Medical Staff Development Plan**
The Board may decline to accept applications based on requirements or limitations in the Hospital's Medical Staff Development Plan, which shall be based on the Hospital's identified scope of patient care needs within its service area.

The Medical Staff Development Plan shall be prepared at the discretion of and by the Board with input from the Chief of Staff and the Medical Executive Committee and may limit the number of Medical Staff appointees within Services, specialties and subspecialties of the Medical Staff and/or the recipients of Clinical Privileges. The Medical Staff Development Plan may be based upon written criteria developed with input from the Chief of Staff, Medical Executive Committee and Service Chairs and a finding by the Chief Executive Officer that such action would be in the best interests of patient care. The written criteria shall consider, as appropriate, the utilization of the Hospital and each Service, specialty or subspecialty, the average waiting time for scheduling elective procedures, the ability to enter into and financial benefit of entering into exclusive agreements for the provision of care, and other factors deemed appropriate in evaluating the desirability or necessity of limiting the number of Medical Staff appointees within a Service, specialty or subspecialty and/or the recipients of Clinical Privileges.

Any such limitation decision shall be approved by the Board, shall be reviewed at least every two (2) years, and may be raised, lowered or rescinded by the Chief Executive Officer after consultation with the applicable Section Chief and concurrence by the Chief of Staff and the Medical Executive Committee and with approval by the Board.

D. **Effects of Declination**
Refusal to extend, accept or review an application for Medical Staff appointment, reappointment or Clinical Privileges shall be based on the Hospital's identified patient care needs and ability to accommodate, as described in this Section, shall not constitute a denial of appointment, reappointment or Clinical Privileges, and shall not entitle the individual to any procedural rights in Article 8. Any portion of the application which is accepted (*e.g.* requests for Clinical Privileges that are not subject to a limitation) shall be processed in accordance with the processes described in these Medical Staff Bylaws.

ARTICLE 2: CATEGORIES OF THE MEDICAL STAFF

Successful acquisition and retention of Medical Staff Membership and Clinical Privileges is a matter to be recommended by the Medical Staff and approved by the Board of Directors ("Board") of the Hospital in accordance with the Credentialing Policy of the Medical Staff. In addition to the qualifications set forth in each category below, appointment and reappointment to the Medical Staff is subject to meeting the qualifications and conditions set forth elsewhere in these Bylaws, including Article 3, as applicable.

Allied Health Professionals, and Advanced Practice Providers who have applied for Clinical Privileges are

governed by a separate Allied Health Professionals Policy and Advanced Practice Provider Policy, respectively, and are subject to these Bylaws, the Rules and Regulations, and other Medical Staff policies and procedures, as applicable, and as further set forth in the applicable Hospital policy.

2.1. GENERAL

A. **Categories**
The Medical Staff shall consist of the following categories: Active Medical Staff, Courtesy Medical Staff, and Member without Privileges. Following their retirement from the Medical Staff, certain Members may be eligible for Honorary Medical Staff recognition, a designation which does not require formal credentialing.

All appointments to the Medical Staff shall be made by the Board and be made to one of the categories identified below. Members of the Medical Staff, regardless of category, shall comply with all federal, state and local laws applicable to the delivery of medical care in an acute care facility that is a participant in Federal Programs, and shall comply with the Medical Staff Documents, directives issued by the Medical Executive Committee, and applicable Hospital policies and procedures including the Corporate Compliance Plan. Members of all categories of the Medical Staff, with the exception of the Honorary Staff, will be assessed annual dues as required under Medical Staff policy and in an amount approved by the Medical Executive Committee.

B. **Limitations on Prerogatives**
The prerogatives of Medical Staff Membership outlined in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Member's appointment or reappointment, by state or federal law or regulation, or other provisions of the Medical Staff Documents, or other policies, commitments, contracts or agreements of the Hospital.

2.2. THE ACTIVE MEDICAL STAFF

A. **Qualifications**
Members of the Active Medical Staff shall consist of physicians, dentists and podiatrists who regularly admit to or are otherwise regularly involved in the treatment or evaluation of patients at the Hospital, who are geographically close enough to the Hospital to provide continuous care for their patients and who assume all the functions and responsibilities of Membership on the Active Medical Staff, including, when appropriate, Emergency Department call responsibilities and attending and/or consulting responsibility for unassigned patients. Hospital-based Members who do not admit patients may be members of the Active Medical Staff if otherwise qualified.

Exceptions to these qualifications may be made if the Board determines that a given Member's expertise is needed to enhance patient care services or improve efficiency of Hospital operations. The Board may also, in its discretion, relieve a Member from Emergency Department call responsibilities as long as others in the Member's medical specialty are available to fulfill such call responsibilities sufficient to meet the needs of the Hospital's primary service area. Any such exceptions may be reviewed and approved by the Board at any time after review and upon recommendation of the Medical Executive Committee.

B. **Prerogatives**
Except as otherwise provided, an Active Medical Staff Member may admit patients and exercise Clinical Privileges that have been granted, attend general and special meetings of the Medical Staff and of the assigned Service and Committees of which they are a member or has been appointed, vote, and hold membership or office on any Hospital, Medical Staff or Board Committee unless otherwise specified in the Medical Staff Documents. Members of the Active Medical Staff may admit patients without limitation subject to availability of beds, except as otherwise provided in the Medical Staff Documents.

C. **Responsibilities**
In addition to fulfilling the general responsibilities of Medical Staff Membership, Active Medical Staff Members shall assume Emergency Department call responsibilities within the Member's clinical specialty unless otherwise excepted, and shall contribute to the organizational and administrative affairs of the Medical Staff, actively participate in recognized Medical Staff functions including quality and performance improvement and risk management activities (with monitoring of other appointees as requested), pay annual dues as required by Medical Staff policy, and discharge other Medical Staff functions as may be required from time to time.

2.3. THE COURTESY MEDICAL STAFF

A. **Qualifications**
Members of the Courtesy Medical Staff include physicians, dentists, and podiatrists otherwise qualified for Medical Staff appointment who have fewer than thirty (30) annual patient encounters.

B. **Prerogatives**
Except as otherwise provided by the Medical Staff Documents, members of the Courtesy Medical Staff are entitled to admit patients to the Hospital and exercise such Clinical Privileges granted to them by the Board. Courtesy Medical Staff Members may attend meetings of the Medical Staff and of the Service to which they are assigned, but have no right to vote at such meetings except where otherwise specified, and may not hold either Medical Staff, Service, or Section office. Serve on Medical Staff committees, except for the Medical Executive Committee, if appointed or elected to serve on such committee.

C. **Responsibilities**
In addition to fulfilling the general responsibilities of Medical Staff Membership, members of the Courtesy Medical Staff must pay annual dues as required under Medical Staff policy and in an amount approved by the Medical Executive Committee, and, in the discretion of the Board after review and recommendation by the Medical Executive Committee, may be required to assume Emergency Department call responsibilities.

D. **Limitation on Patient Encounters**
A Courtesy Staff Member will be limited to ninety (90) patient encounters, as defined in these Bylaws, in any thirty-six (36) month appointment term. No more than one "encounter" shall be considered for any patient, per admission, for whom the Courtesy Staff Member is the admitting or consulting physician. If this limitation on encounters is exceeded, the Courtesy Staff member shall be considered for advancement to Active Medical Staff status.

2.4. THE MEMBERSHIP WITHOUT PRIVILEGES STAFF

A. **Qualifications**
Members of the Membership Without Privileges Staff include physicians, dentists, and podiatrists otherwise qualified for Medical Staff appointment but are not granted Clinical Privileges. This category may be held by Members who in a twelve (12) month period, have no patient encounters at the Hospital as reflected in the Hospital's medical records and other documents. Exceptions to these qualifications may be made if the Board determines that a given Member's expertise is needed to enhance patient care services or improve efficiency of Hospital operations.

B. **Prerogatives**
Except as otherwise provided by the Medical Staff Documents, members of the Membership Without Privileges Staff are entitled to attend meetings of the Medical Staff and of the Service to which they are assigned, but have no right to vote at such meetings except where otherwise specified, and may not hold either Medical Staff, Service, or Section office. Serve on Medical Staff committees, except for the Medical Executive Committee, if appointed or elected to serve on such committee. Membership Without Privileges Staff are permitted to view patient medical records, but are not permitted to document and/or amend the record.

C. **Responsibilities**
In addition to fulfilling the general responsibilities of Medical Staff Membership, members of the Membership Without Privileges must pay annual dues required under Medical Staff policy and in an amount approved by the Medical Executive Committee. Membership Without Privileges Staff are not required to take Emergency Department call responsibilities, provide alternate coverage, or maintain a Drug Enforcement Administration (DEA) registration as they do not hold Clinical Privileges.

2.5. THE HONORARY MEDICAL STAFF RECOGNITION

A. **Qualifications**
The Honorary Medical Staff recognition may be extended to Physicians, Dentists, and Podiatrists who have retired from active Hospital practice, who are honored by emeritus status, or who are deemed deserving of Membership because of their outstanding professional reputation and/or previous long-standing service to the Hospital. Honorary Medical Staff members, who are not required to hold an active Kansas medical license, are recognized but not formally appointed to the Medical Staff through the credentialing process.

B. **Prerogatives**
Honorary Staff members are ineligible to admit patients to the Hospital, ineligible for formal appointment to the Medical Staff, ineligible for Clinical Privileges, and, may not vote or hold office on the Medical Staff. However, Honorary Staff may attend, and, as required to fulfill specific commitments, serve on Hospital and Medical Staff Committees with a vote consistent with commitments or Committees. Honorary Medical Staff Members may attend educational and social functions of the Hospital and Medical Staff.

C. **Responsibilities**
Requests for Honorary Medical Staff recognition shall be made in writing to the Medical Executive Committee in care of the Medical Staff Office, typically with the Member's written

notice of retirement from the Medical Staff. Individuals recognized with Honorary Medical Staff status are required to comply with the Medical Staff Documents and Hospital policies and procedures, as applicable to the extent of their involvement in Medical Staff and Hospital activities. They are not assessed annual dues.

2.6. CHANGE IN STAFF CATEGORY

Pursuant to a request by a Medical Staff member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in medical staff category of a member consistent with the requirements of the Medical Staff Documents. The Medical Staff member must provide a sixty (60) day notice if the Member request to change from Active to Courtesy or Active to Membership without Privileges. The Board shall approve any change in category and grant the effective date of the change.

2.7. SUPERVISED CLINICAL ROTATIONS

The terms "medical students," "interns," and "residents" as used in these Bylaws, refer to individuals currently enrolled in undergraduate medical education programs (i.e., MD,DO) and graduate medical education programs who provide supervised health care services at the Hospital as part of their education and training. These individuals, as well as students enrolled in physicians' assistant and advanced registered nurse practitioner educational programs and other clinical rotation programs approved by the Medical Executive Committee:

A. are *not* considered Independent Practitioners;

B. are *not* members of the Medical Staff or Allied Health Professionals;

C. are *not* entitled to any of the rights, privileges, or to the hearing or appeal rights under the Medical Staff Documents;

D. do *not* participate in any credentialing process sponsored by the Hospital; rather, are credentialed by the sponsoring medical school or educational program in accordance with provisions in a written affiliation agreement between the Hospital and the school/program, with such credentialing information made available to the Hospital and/or Medical Staff upon request; and

E. shall comply with medical staff policies/procedures, rules/regulations and Hospital policies and procedures.

The Medical Staff Policy titled "Clinical Rotation Policy" is the guidance document directing appropriate and consistent supervision of these individuals.

ARTICLE 3: PROCESS FOR APPOINTMENT AND REAPPOINTMENT

3.1. GENERAL CONDITIONS

A. **Effect of Application for Appointment/Reappointment**

By applying for Medical Staff appointment, reappointment and/or Clinical Privileges, the applicant:

1. authorizes representatives of the Hospital and/or the Medical Staff to solicit and act upon information, including otherwise privileged or confidential information provided by third parties and/or entities bearing on their credentials and agrees that any information so provided shall not be required to be disclosed to the applicant if the third party providing such information does so only on the condition that the information be kept confidential;
2. authorizes third parties to release information to representatives of the Hospital and/or the Medical Staff, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations, and other documents in their possession bearing on the applicant's credentials, and consents to the inspection and procurement by the Hospital of such information, records and other documents;
3. authorizes the Hospital to maintain information concerning the applicant's age, training, board certification, licensure and other confidential information in a centralized physician database for the purpose of making aggregate physician information available for use by the Hospital;
4. authorizes the Hospital to release confidential information, including peer review and/or performance improvement information, obtained from or about the applicant to peer review committees of the Medical Staff and Hospital for purposes of reducing mortality and morbidity and for the improvement of patient care;
5. agrees to appear for a personal interview at any reasonable time regarding any information pertaining to the application, as requested by any representative of the Hospital and/or Medical Staff;
6. *upon request of the applicant*, authorizes representatives of the Hospital and/or the Medical Staff to release information, including otherwise privileged or confidential information bearing on the applicant's credentials, to other healthcare entities, who solicit such information for the purpose of evaluating their professional qualifications pursuant to a request for appointment, reappointment or Clinical Privileges;
7. consents to the reporting by Hospital representatives of any information which is required by law or regulation to be reported to the National Practitioner Data Bank, the Kansas Board of Healing Arts, or any other similar entity;
8. agrees that, if any adverse decision is made with respect to the application, the applicant shall follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws as a prerequisite to any other action, and that the applicant shall have the burden of demonstrating that they meet the standards for appointment or continued appointment to the Medical Staff and/or for the Clinical Privileges requested;
9. agrees to comply with and be bound by the Medical Staff Documents, and the Hospital's Corporate Compliance Plan and policies/procedures;
10. agrees to comply with all applicable federal, state and municipal laws/regulations and hospital accreditation standards that apply to Medical Staff Members;

11. agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any other application or agreement.
12. understands that a government sanctioned exclusion databases, state licensure database, National Practitioner Database (NPDB), and Fraud Abuse Control Information Systems (FACIS) database will be queried on a periodic basis in addition to the appointment, reappointment or additional privilege applications process.
13. agrees to attend available training and comply with the use of the electronic medical record system.

B. **Immunity from Liability**

1. *Immunity and Release*
   By applying for and/or accepting appointment to the Medical Staff and/or applying for, accepting and exercising Clinical Privileges, the applicant extends absolute immunity to, and releases from all claims, damages and liability:
   a. any and all Hospital and Medical Staff representatives for any statement, action taken, or recommendation made by same within the scope of their duties and in compliance with the Medical Staff Documents, including disclosures made to other healthcare entities pursuant to the Medical Staff Documents; and
   b. any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital or Medical Staff representative concerning the applicant unless such information is false the third party has direct knowledge of the falsity.
2. *Scope of Immunity and Release*
   The immunity so provided by the Medical Staff Documents shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection to the Hospital's activities, including but not limited to:
   a. application for appointment, reappointment and Clinical Privileges, including inquiries from other healthcare entities regarding the credentials of a Member;
   b. periodic performance appraisals undertaken for reappointment, requests for new privileges or pursuant to the Hospital's performance improvement and risk management activities;
   c. recommendations for and corrective actions taken, including professional review actions and the investigative processes resulting in same;
   d. Fair Hearings and appellate review;
   e. peer review and monitoring/evaluating activities for the purposes of maintaining quality patient care and appropriate professional conduct within the Hospital; and
   f. reporting to the National Practitioner Data Bank, Kansas Board of Healing Arts, and/or other similar entities as may be required by law or regulation.

C. **Burden on the Applicant**

1. An applicant for Medical Staff appointment, reappointment and/or Clinical Privileges shall be responsible for producing adequate, accurate information to properly evaluate their experience, background, training, demonstrated competence, character, physical/mental health status and/or any other criteria or qualification specified in these Medical Staff Bylaws, as determined by the Chief of Service (or designee), Credentials Committee, Medical Executive Committee, or Board to resolve any doubts or conflicts regarding the application, and/or to clarify information as requested.
2. An application for appointment, reappointment and/or Clinical Privileges shall not be considered a "Completed Application" until all requested information and documentation is provided, and an application may be deemed "incomplete" at any stage of the credentialing process if additional information is deemed necessary to affect a complete and adequate evaluation of the applicant.
3. The applicable Chief of Service, Credentials Committee, Medical Executive Committee and/or the Board may request an applicant appear for an informal interview regarding the application. The Medical Staff Office shall provide written Notice to the applicant of the information and/or interview request, the specific information requested and/or to be discussed, and the timeframe within which a response from the applicant is required.
    a. Failure by an applicant to appear for an interview or produce all additional requested information within thirty (30) days of the applicant's receipt of the written request, the applicant will be deemed to have voluntarily withdrawn their application. The applicant shall be notified by Special Notice that their application is barred from further processing and is considered withdrawn. Thereafter, if the applicant desires appointment, reappointment or Clinical Privileges, the applicant shall be required to submit a new application for same. The new application shall not be processed unless all previously requested information is provided by the applicant.
4. Any Material Misrepresentation of information by an applicant during the application process, either by commission or omission, shall render the application for appointment, reappointment and/or Clinical Privileges ineligible for further processing.
    a. When it appears at any stage of the application process that an applicant seeking appointment or reappointment and/or Clinical Privileges has provided inaccurate information which may constitute a Material Misrepresentation, processing of the application shall cease. The applicant may be informally interviewed by the Credentials Committee.
        i. Such interview shall be conducted informally, and the affected applicant shall be allowed to present information, but shall have no right to call witnesses unless specifically granted by the Credentials Committee in its sole discretion, or be represented by legal counsel.

ii. If, following such interview the Credentials Committee determines a Material Misrepresentation was made, the application shall be considered voluntarily withdrawn and the applicant shall not be eligible to reapply for appointment/Clinical Privileges at the Hospital for three (3) years from the date of the voluntary withdrawal. The applicant will be notified by Special Notice that the application has been deemed to have been voluntarily withdrawn, that the applicant is not eligible to reapply for three (3) years, and that the applicant is not entitled to a hearing or appeal under these Medical Staff Bylaws.

D. **Assistance with Evaluation**
The Chief of Service, the Credentials Committee, the Medical Executive Committee or the Board, as part of the review and evaluation of applications for Medical Staff Membership and/or Clinical Privileges, or the ongoing review/evaluation of performance of Members or those holding Clinical Privileges, may as part of those responsibilities:

1. obtain the assistance of any independent consultant, including to interview the applicant/Member under evaluation and/or participate in peer review activities;
2. consider the results of performance improvement activities or outcomes data from other hospitals or health care entities regarding the applicant/Member under evaluation;
3. subject to appropriate protection of patient confidentiality, require the applicant/Member under evaluation to produce copies medical records of patients treated by him/her from other health care settings other than the Hospital for review/evaluation of the care provided; and/or
4. require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the applicant/Member under evaluation, including threatened pending legal or administrative proceedings.

E. **Reapplication Following Withdrawal of Application or Final Adverse Action**
An applicant who has received a final adverse decision regarding, or who has withdrawn an application for appointment, reappointment or Clinical Privileges to avoid a possible adverse action, is ineligible to reapply, as applicable, for appointment, reappointment or Clinical Privileges for a period of at least three (3) years. Any re-application following this time period shall be processed as an initial application and the applicant must submit additional information, as may be required by the Chief of Service, Credentials Committee, Medical Executive Committee and/or the Board, to satisfactorily demonstrate that the basis for any earlier adverse action or application withdrawal has been resolved. If the additional information submitted does not satisfactorily resolve the basis for the earlier adverse action or application withdrawal, or if it appears the new application is based on substantially the same information as when previously denied or withdrawn, then the application shall be deemed incomplete and not processed. The applicant shall be notified of such in writing by certified mail, return receipt requested. No hearing or appeals rights shall be available in this event.

F. **Conditional Appointment/Reappointment/Privileges**
In lieu of recommending a professional review action, the Credentials and/or Medical

Executive Committee may recommend appointment, reappointment and/or the grant of Clinical Privileges contingent upon the applicant's voluntary agreement to comply with certain conditions. Such conditions may be imposed due to professional conduct or clinical competence concerns. The applicant shall execute a document agreeing to such conditions as recommended by the Medical Executive Committee, which shall accompany the Medical Executive Committee's recommendation to the Board regarding the applicant's appointment, reappointment and/or Clinical Privileges. The Board shall have final authority regarding such appointment, reappointment and/or the grant of Clinical Privileges subject to the conditions recommended by the Medical Executive Committee. The applicant's voluntary execution of the document detailing such conditions shall not entitle him/her to the procedural entitlements described in these Medical Staff Bylaws and the imposition of such conditions shall not cause a report to the National Practitioner Data Bank.

3.2. INITIAL APPOINTMENT

A. **Submission of the Application**
The application for Medical Staff appointment and/or Clinical Privileges shall be submitted to the Medical Staff Office accompanied by payment of any required application processing fee. An applicant must also provide with the application a current photograph and state or federal photo identification.

B. **Processing the Application**

1. *Verification of Information*
The Medical Staff Office shall attempt to expeditiously verify the information submitted by the applicant by confirmation with primary sources in good faith and to the extent possible, in accordance with the Credentialing Policy and Medical Staff Office policies/procedures.

The Medical Staff Office shall notify the applicant of any problems/delays in the data collection/verification efforts and the applicant shall bear the burden to assist with the data collection, as requested. If the applicant does not respond to such request for assistance within thirty (30) days of such request, the application shall be considered voluntarily withdrawn in accordance with Section 3.1(C) and the applicant so notified.

2. *Chief of Service Procedure*
No later than thirty (30) days from completion of the application verification process, the Medical Staff Office shall transmit the application and all supporting information to the Chief of Service (or designee) of the Service in which the applicant seeks privileges when the former reasonably believes all necessary information to process the application has been supplied and such information verified. The Chief of Service (or designee) shall review the applicant's credentials and requested privileges and determine if additional information is required of the applicant in order to adequately evaluate the applicant's credentials. The Chief of Service (or designee) may require a meeting with the applicant to accomplish this evaluation and continue the application processing. If additional information and/or a meeting is required, the applicant shall be notified and shall bear the burden of meeting with the Chief of Service (or designee) and/or producing the additional information in accordance

with Section 3.1(C). Until such information is supplied, that aspect of the appointment application or request for Clinical Privileges shall be deemed incomplete.

Following receipt of any further requested information, the Chief of Service (or designee) shall issue a written recommendation regarding whether the applicant has established and satisfied all of the necessary qualifications for Membership and for the Clinical Privileges sought, and the basis for such recommendation. The Chief of Service's (or designee's) recommendation shall be transmitted to the Credentials Committee.

3. *Credentials Committee Procedure*
   The Credentials Committee shall examine the submitted application and all supporting documentation regarding the applicant's character, education and training, current clinical competence, qualifications, ethical standing and other criteria, and shall determine, based on references provided by the applicant, the recommendation of the Chief of Service, and from other sources available to the Committee, whether the applicant has established and satisfied all of the necessary criteria for Membership and the requested Clinical Privileges. The Credentials Committee shall prepare a written recommendation for the Medical Executive Committee regarding appointment, staff category, assigned Service, and Clinical Privileges to be granted (with the imposition of any special conditions, as indicated). In the event the recommendation is adverse to the applicant, the Credentials Committee shall state the supporting reasons. To the extent reasonably possible, the time frame for completion of the Credentials Committee activity on the application shall be at the next regularly scheduled meeting of the Committee following receipt of the Chief of Service recommendation.

   The Credentials Committee may request any additional information necessary to assist in its deliberations and may require a meeting with the applicant. The meeting, if requested, will not constitute a "hearing" as that term is used in these Bylaws, nor will the hearing and appeal procedures apply, and the applicant is not entitled to have an attorney participate in the interview. If additional information and/or a meeting is required, the applicant shall be notified and shall bear the burden of appearing before the Committee and/or producing the additional information or in accordance with Section 3.1(C). Until such information is supplied, that aspect of the appointment application or request for Clinical Privileges shall be deemed incomplete.

4. *Medical Executive Committee Procedure*
   The Medical Executive Committee shall receive from the Credentials Committee and review the application, supporting materials the recommendations of the Chief of Service and Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written recommendation for the Board regarding appointment, staff category, assigned Service, and Clinical Privileges to be granted (with the imposition of any special conditions, as indicated). In the event the recommendation is adverse to the applicant, the Medical Executive Committee shall state the supporting reasons. To the extent reasonably possible, the time frame for completion of the

Medical Executive Committee activity on the application shall be at the next regularly scheduled meeting of the Committee following receipt of the Credentials Committee recommendation.

The Medical Executive Committee may require a meeting with the applicant to discuss any aspect of the application. If additional information and/or a meeting is required, the applicant shall be notified and shall bear the burden of appearing before the Committee and/or producing the additional information or in accordance with Section 3.1(C). Until such information is supplied, that aspect of the appointment application or request for Clinical Privileges shall be deemed incomplete.

A favorable recommendation by the Medical Executive Committee regarding appointment/Clinical Privileges shall be contingent upon review and ascertainment that the applicant's health status is such that they are able to perform the procedures for which the applicant has requested privileges, with or without accommodation, according to accepted standards of professional practice, as attested to by the applicant on the application form.

Following a recommendation by the Medical Executive Committee to appoint and/or grant Clinical Privileges, the Chair of the Practitioner Health Committee or the Chief of Staff shall review the Health Questionnaire completed by the applicant prior to any action by the Board. If information is contained therein suggesting the applicant may have a health impairment which might reasonably prevent the applicant from performing the requested privileges according to accepted standards of professional practice, the application shall not be forwarded to the Board for action. Instead, the application shall be referred to the Practitioner Health Committee which shall evaluate the issue in accordance with the process described in the Medical Staff policy titled "Practitioner Health Policy", and make a recommendation to the Medical Executive Committee.

Following such evaluation and recommendation by the Practitioner Health Committee, the Medical Executive Committee shall reconsider the request for appointment and/or Clinical Privileges in light of this new information before making a recommendation to the Board. Such recommendation and subsequent Board action shall be in accordance with Section 3.3. As may be deemed appropriate by the Practitioner Health Committee or the Medical Executive Committee, a recommendation to the Board for appointment, reappointment and/or Clinical Privileges may be made contingent upon the applicant's agreement to monitoring if a pre-existing health problem warrants such monitoring.

a. Effect of Medical Executive Committee Recommendation

    i. Deferral
    The Medical Executive Committee may defer making a recommendation regarding an application where the deferral is not solely for the purpose of causing a delay. A decision to defer further consideration of the application shall state the reasons for deferral, provide direction for further investigation, and state

time limits for such further investigation. As soon as practical after the deferral, a favorable or adverse recommendation regarding the application shall be made. The Medical Executive Committee may delegate the responsibility for further consideration to the Credentials Committee or Chief of Service as appropriate.

ii. Favorable Recommendation
When the recommendation of the Medical Executive Committee is favorable to the applicant, the application shall be forwarded to the Board for action at the Board's next regularly scheduled meeting.

iii. Adverse Recommendation
If the recommendation of the Medical Executive Committee is adverse to the applicant, the applicant shall be notified in writing of such by the Chief of Staff, delivered by certified mail, return receipt requested. Such notice shall contain the information prescribed in these Medical Staff Bylaws. No such adverse recommendation shall require forwarding to the Board until after the applicant has waived or exercised their rights under these Medical Staff Bylaws.

5. *Action by the Board*
Unless subject to the provisions of the hearing and appeals provisions of these Medical Staff Bylaws, the Board shall act on the application at its next regularly scheduled meeting following receipt of the recommendation from the Medical Executive Committee.

If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Board.

If the Board does not adopt the recommendation of the Medical Executive Committee, the Board may either refer the matter back to the Medical Executive Committee with instructions for further review/evaluation and a timeframe for responding back to the Board or the Board may take action on its own initiative. The Board may take action on its own initiative using the same type of criteria considered by the Medical Executive Committee but only after informing the Medical Executive Committee of its intent and allowing a reasonable period of time for response by the Medical Executive Committee. If the Board refers the matter back to the Medical Executive Committee, the Medical Executive Committee shall review the matter as instructed by the Board and shall forward its subsequent recommendation to the Board. If the Board then adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Board.

All decisions to appoint shall include a delineation of Clinical Privileges, the assignment of Staff category and Service affiliation, noting any applicable conditions placed on the appointment or grant of Clinical Privileges. The applicant shall be provided written notification of such action.

6. *Time Guidelines for Acting*
   All individuals and groups required to act on an application for appointment/Clinical Privileges deemed to be complete shall do so in good faith and, except for good cause, complete their actions within the following time frames:

Medical Staff Office	60 days
Chief of Service	30 days
Credentials Committee	Next regular meeting
Medical Executive Committee	Next regular meeting
Board	Next regular meeting

   These time frames are considered guidelines only and do not create any right for an applicant to have an application processed within these precise periods of time; provided, that this provision shall not apply if these Medical Staff Bylaws is triggered by an adverse recommendation or action, when is such case the time requirements set forth in these Medical Staff Bylaws shall govern the continued processing of the application.

3.3. REAPPOINTMENT

A. **Initiation of Reappointment Process**
   At least one hundred twenty (120) days prior to the date of expiration of an individual's appointment and/or Clinical Privileges, the Medical Staff Office shall inform the individual of the pending expiration date and provide a reappointment application form. No later than ninety (90) days prior to the expiration date, the applicant for reappointment shall submit a completed reappointment application to the Medical Staff Office.

B. **Reappointment Application Form**
   The application for reappointment shall be made on a specialized form approved by the Credentials Committee and shall be substantially similar to the application for appointment described in Section 1.1 of the Medical Staff Credentialing Policy. The reappointment form shall require the applicant to specifically request the Clinical Privileges they are seeking for the pending reappointment term; however, additional Clinical Privileges may be requested at any time.

C. **Failure to File Reappointment Application**
   Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the individual's admitting privileges and expiration of other Clinical Privileges and prerogatives at the end of the current Medical Staff Year. If an individual fails without good cause to submit a completed application for reappointment within forty-five (45) days after the date it was due, the individual shall be deemed to have resigned Membership in the Medical Staff. In the event Medical Staff Membership terminates for the reasons set forth in this section, the procedures set forth in Article 8 of the Medical Staff Bylaws shall not apply.

D. **Evaluation of Applicant for Reappointment**

   1. *General*
      An applicant for reappointment to the Medical Staff and/or the renewal/addition of Clinical Privileges shall be evaluated regarding:

      a. their professional competence and clinical judgment in the treatment of

patients since last appointed to the Medical Staff;

b. recommendations from peers specifically addressing current competence;

c. references and other data, as applicable, from other hospitals and healthcare entities with which the applicant is affiliated, including the voluntary or involuntary termination of Medical Staff Membership or the voluntary or involuntary limitation, reduction or loss of Clinical Privileges at such other facilities;

d. continued physical and mental health sufficient to perform the procedures for which Clinical Privileges are sought, maintenance of professional liability insurance coverage in compliance with the Medical Staff Bylaws;

e. the applicant's professional conduct since their last reappointment;

f. their participation in continuing education;

g. the applicant's clinical activity at the Hospital since last appointed to the Medical Staff;

h. maintenance of specialty Board Certification or re-certification;

i. compliance with the Medical Staff Documents and the Hospital's Corporate Compliance and Risk Management Plans and applicable policies/procedures since last appointed to the Medical Staff;

j. the applicant's pledge to provide continuous care for their patients;

k. The results of OPPE, FPPE, and any Peer Review regarding the individual's clinical performance as set forth in the Hospital policies on professional practice evaluation;

l. other information regarding the applicant's professional practice, case history, quality of care, and patient outcomes, including but not limited to the applicant's malpractice claims history and resource utilization activities at the Hospital since last appointed to the Medical Staff;

m. ability to work cooperatively with peers, Hospital employees and the Board; general character of the applicant's relationships with patients and the Hospital; and

n. other criteria as appropriate to evaluate the applicant's clinical competency and professional conduct.

E. **Processing the Application**

1. *Verification of Information*
The Medical Staff Office shall attempt to expeditiously verify the information submitted by the applicant by confirmation with primary sources in good faith and to the extent possible, in accordance with the Medical Staff Office policies and procedures. The date the applicant signed the application and the date of the query findings from the American Medical Association, Kansas Board of Healing Arts, OIG, National Practitioner Data Bank, Fraud Abuse Control Information System (FACIS), System for Award Management (SAMS), Drug Enforcement Agency as applicable, shall be current within six (6) months at the time the application is reviewed by the

Credentials Committee. If this six-month time period is exceeded, the applicant shall be required to submit a new application and verification queries shall be repeated. In such event, the applicant's current appointment term and/or grant of Clinical Privileges may expire before the application is processed through the Board. The applicant shall not be permitted to exercise privileges at the Hospital until the reappointment and/or grant of Clinical Privileges is made final by Board action.

The Medical Staff Office shall notify the applicant by of any problems/delays in the data collection/verification efforts and the applicant shall bear the burden to assist with the data collection, as requested. If the applicant does not respond to such request for assistance within thirty (30) days of such request, the application shall be considered voluntarily withdrawn in accordance with Section 3.1(C) and the applicant so notified.

2. *Chief of Service Procedure*
No later than thirty (30) days from completion of the application verification process, the Medical Staff Office shall transmit the verified reappointment application and/or request for Clinical Privileges along with all supporting information to the Chief of Service (or designee) of the Service in which the applicant seeks reappointment/ privileges. The Chief of Service (or designee) shall review the applicant's credentials and requested privileges and determine if additional information is required of the applicant in order to adequately evaluate the applicant's credentials. The Chief of Service (or designee) may require a meeting with the applicant to accomplish this evaluation and continue the application processing. If additional information and/or a meeting is required, the applicant shall be notified and shall bear the burden of meeting with the Chief of Service (or designee) and/or producing the additional information in accordance with Section 3.1(C). Until such information is supplied, that aspect of the appointment application or request for Clinical Privileges shall be deemed incomplete.

Following receipt of any further requested information, the Chief of Service (or designee) shall issue a written recommendation regarding whether the applicant has established and satisfied all of the necessary qualifications for reappointment and for the Clinical Privileges sought, and the basis for such recommendation. The Chief of Service's (or designee's) recommendation shall be transmitted to the Credentials Committee.

3. *Credentials Committee Procedure*
The Credentials Committee shall examine the submitted application for reappointment and/or Clinical Privileges and all supporting documentation regarding the applicant's character, education and training, current clinical competence, qualifications, ethical standing and other criteria, and shall determine, based on references provided by the applicant, the recommendation of the Chief of Service, and from other sources available to the Committee, whether the applicant has established and satisfied all of the necessary criteria for Membership and the requested Clinical Privileges. The Credentials Committee shall prepare a written recommendation for the Medical Executive Committee regarding appointment, staff category, assigned Service, and Clinical Privileges to be granted (with the imposition of any special conditions, as indicated). In the event the recommendation is adverse

to the applicant, the Credentials Committee shall state the supporting reasons. To the extent reasonably possible, the timeframe for completion of the Credentials Committee activity on the application shall be at the next regularly scheduled meeting of the Committee following receipt of the Chief of Service recommendation.

The Credentials Committee may require a meeting with the applicant to discuss any aspect of the application. If additional information and/or a meeting is required, the applicant shall be notified and shall bear the burden of appearing before the Committee and/or producing the additional information in accordance with Section 3.1(C). Until such information is supplied, that aspect of the appointment application or request for Clinical Privileges shall be deemed incomplete.

4. *Medical Executive Committee Procedure*
The Medical Executive Committee shall receive from the Credentials Committee and review the reappointment application and/or request for Clinical Privileges, supporting materials, the recommendations of the Chief of Service and Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written recommendation for the Board regarding appointment, staff category, assigned Service, and Clinical Privileges to be granted (with the imposition of any special conditions, as indicated). In the event the recommendation is adverse to the applicant, the Medical Executive Committee shall state the supporting reasons. To the extent reasonably possible, the timeframe for completion of the Medical Executive Committee activity on the application shall be at the next regularly scheduled meeting of the Committee following receipt of the Credentials Committee recommendation.

The Medical Executive Committee may require a meeting with the applicant to discuss any aspect of the application. If additional information and/or a meeting is required, the applicant shall be notified and shall bear the burden of appearing before the Committee and/or producing the additional information in accordance with Section 3.1(C). Until such information is supplied, that aspect of the appointment application or request for Clinical Privileges shall be deemed incomplete.

A favorable recommendation by the Medical Executive Committee regarding appointment/Clinical Privileges shall be contingent upon review and ascertainment that the applicant's health status is such that they are able to perform the procedures for which the applicant has requested privileges, with or without accommodation, according to accepted standards of professional practice, as attested to by the applicant on the application form.

Following a recommendation by the Medical Executive Committee to reappoint and/or grant Clinical Privileges, the Chair of the Practitioner Health Committee or the Chief of Staff shall review the Health Questionnaire completed by the applicant prior to any action by the Board. If information is contained therein suggesting the applicant may have a health impairment which might reasonably prevent the applicant from performing the requested privileges according to accepted standards

of professional practice, the application shall not be forwarded to the Board for action. Instead, the application shall be referred to the Practitioner Health Committee which shall evaluate the issue in accordance with the process described in the Medical Staff policy titled "Practitioner Health Policy", and make a recommendation to the Medical Executive Committee.

Following such evaluation and recommendation by the Practitioner Health Committee, the Medical Executive Committee shall reconsider the request for reappointment and/or Clinical Privileges in light of this new information before making a recommendation to the Board. Such recommendation and subsequent Board action shall be in accordance with Section 3.3. As may be deemed appropriate by the Practitioner Health Committee or the Medical Executive Committee, a recommendation to the Board for appointment, reappointment and/or Clinical Privileges may be made contingent upon the applicant's agreement to monitoring if a pre-existing health problem warrants such monitoring.

a. Effect of Medical Executive Committee Recommendation

i. Deferral
The Medical Executive Committee may defer making a recommendation regarding an application where the deferral is not solely for the purpose of causing a delay. A decision to defer further consideration of the application shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, a favorable or adverse recommendation regarding the application shall be made. The Medical Executive Committee may delegate the responsibility for further consideration to the Credentials Committee or Chief of Service as appropriate.

ii. Favorable Recommendation
When the recommendation of the Medical Executive Committee is favorable to the applicant, the application shall be forwarded to the Board for action at the Board's next regularly scheduled meeting.

iii. Adverse Recommendation
If the recommendation of the Medical Executive Committee is adverse to the applicant, the applicant shall be notified in writing of such by the Chief of Staff, delivered by certified mail, return receipt requested. Such notice shall contain the information prescribed in these Medical Staff Bylaws. No such adverse recommendation shall require forwarding to the Board until after the applicant has waived or exercised their rights under these Medical Staff Bylaws.

5. *Action by the Board*
Unless subject to the provisions of the hearing and appeals provisions of these Medical Staff Bylaws, the Board shall act on the application at its next regularly

scheduled meeting following receipt of the recommendation from the Medical Executive Committee.

If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Board.

If the Board does not adopt the recommendation of the Medical Executive Committee, the Board may either refer the matter back to the Medical Executive Committee with instructions for further review/evaluation and a time frame for responding back to the Board or the Board may take action on its own initiative. The Board may take action on its own initiative using the same type of criteria considered by the Medical Executive Committee but only after informing the Medical Executive Committee of its intent and allowing a reasonable period of time for response by the Medical Executive Committee. If the Board refers the matter back to the Medical Executive Committee, the Medical Executive Committee shall review the matter as instructed by the Board and shall forward its subsequent recommendation to the Board. If the Board then adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Board.

All decisions to reappoint shall include a delineation of Clinical Privileges, any change in assignment of Staff category and Service affiliation, noting any applicable conditions placed on the reappointment or grant of Clinical Privileges. The applicant shall be provided written notification of such action.

6. *Time Guidelines for Acting*
All individuals and groups required to act on an application for reappointment/Clinical Privileges deemed complete shall do so in good faith and, except for good cause, complete their actions within the following time frames:

Medical Staff Office	60 days
Chief of Service	30 days
Credentials Committee	Next regular meeting
Medical Executive Committee	Next regular meeting
Board	Next regular meeting

These time frames are considered guidelines only and do not create any right for an applicant to have an application processed within these precise periods of time; provided, that this provision shall not apply if the hearing and appeal rights set forth in these Bylaws are triggered by an adverse recommendation or action, when in such case the time requirements set forth in the Article 8 shall govern the continued processing of the application.

No term of reappointment or grant of Clinical Privileges shall extend beyond thirty-six (36) months and such reappointment/Clinical Privileges shall automatically lapse when such time frame is exceeded.

3.4. EXPEDITED CREDENTIALING

A. ***Expedited Process***

In lieu of review by the full Board of requests for new, initial appointment or reappointment to the Medical Staff, and granting, renewal, or modification of Clinical Privileges, the Board may delegate authority for review to a committee of at least two (2) voting members of the Board, provided, however that:

1. Such expedited review shall not be available where:
    a. an applicant submits an incomplete application;
    b. the Medical Executive Committee makes a recommendation that is adverse; or
    c. the Medical Executive Committee makes a recommendation that an Application be approved but that the Clinical Privileges requested be limited.
2. Such expedited review is considered on a case-by-case basis, but is usually unavailable where:
    a. there is a current challenge or a previously successful challenge to the applicant's licensure or registration
    b. the applicant has received an involuntary termination of medical staff Membership at another health care entity;
    c. the applicant has received involuntary limitation, reduction, denial, or loss of Clinical Privileges; or
    d. the Hospital determines that there has been an unusual pattern of, or an excessive number of, professional liability actions resulting in final judgment against the applicant.

3.5. TERMS OF APPOINTMENT

All appointments, reappointments and the grant of Clinical Privileges shall be made by the Board upon recommendation of the Medical Executive Committee and shall be consistent with the Medical Staff Documents.

A. **Initial Appointment**
All initial appointments shall be made and all initial Clinical Privileges shall be granted for up to thirty-six (36) months from the date of Board action. The patient care provided by the Member shall be consistent with the Privileges granted.

B. **Reappointment**
Reappointments with or without the grant of Clinical Privileges shall be for a period not to exceed thirty-six (36) months.

C. **Failure to Timely Submit Application**
In the event that reappointment or Clinical Privileges have not been renewed before the lapse of the current term due to the failure of the applicant to submit a Completed Application, the Membership and Clinical Privileges of the affected Member shall be deemed voluntarily surrendered. In such event, the Member shall be so notified and advised that the submission of a new application is required if continued Membership or Clinical Privileges are required. Voluntary surrender of Membership or Clinical Privileges shall not entitle the Member to a

hearing and appeal as set forth in Article 8 of these Bylaws.

ARTICLE 4: CLINICAL PRIVILEGES

4.1. CLINICAL PRIVILEGES

A. Scope

1. Medical Staff appointment or reappointment shall not automatically confer any Clinical Privileges or right to practice in the Hospital. Each Physician or Dentist who has been given an appointment to the Medical Staff of the Hospital shall be entitled to exercise only those Clinical Privileges specifically recommended by the Medical Staff and approved by the Board.
2. The Clinical Privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information.
3. Each Practitioner and APP granted Clinical Privileges shall be evaluated in an ongoing manner in accordance with the Medical Staff Documents, and the Hospital's Performance Improvement and Risk Management Plans, and other applicable policies and procedures, and shall cooperate with such monitoring and evaluation activities.
4. All initial grants of Clinical Privileges to Practitioners and APPs shall be subject to an initial period of FPPE in accordance with the Focused Professional Practice Evaluation for Granting Privileges Medical Staff Policy (the "FPPE Policy"). Except as otherwise determined by the Executive Committee or as otherwise required by Hospital or Medical Staff policy, AHPs are not subject to initial FPPE.
    a. If a Practitioner or APP refuses to participate in the initial FPPE or fails to successfully complete initial FPPE in accordance with the FPPE Policy, such Practitioner's or APP's Clinical Privileges subject to the FPPE shall be automatically relinquished in accordance with Section 7.1 of these Bylaws.
5. Surgical procedures performed by Dentists shall be under the overall supervision of the Chief of Service to which they have been assigned or such Chief of Service's designee. A medical history and physical examination of any patient upon whom a surgical procedure is to be performed by a Dentist shall be made and recorded by a Physician who is a Member of the Medical Staff before the surgery is performed, and a designated Physician who is a Member of the Medical Staff shall be responsible for the diagnosis and management of the medical problems of any such patient which may be present or arise during the period of hospitalization.

B. Applicant's Burden

1. The Member applying for Clinical Privileges shall have the burden of providing sufficient evidence to support such Member's qualifications and competence to exercise any Clinical Privileges such member's requests.

C. Delineation of Clinical Privileges

1. Application

Clinical Privileges may be granted only pursuant to formal request on forms provided by the Hospital subject to verification of credentials and qualifications, recommendation by the Service Chair, Credentials Committee and Medical Executive Committee and approval by the Board.

Each application for appointment and/or reappointment must contain a request for the specific Clinical Privileges if so desired by the applicant. An application for Clinical Privileges without a request for Medical Staff Membership shall contain the same information as an application for Membership. An applicant for Clinical Privileges shall be subject to the same obligations as are imposed upon an applicant for Medical Staff appointment and/or reappointment.

2. Admitting Privileges
   The privilege to admit is not automatic and shall be delineated and granted by the Board in accordance with the Medical Staff Documents.

4.2. MODIFICATION OF CLINICAL PRIVILEGES

A. Any Member of the Medical Staff, APP, or AHP who wishes to augment or otherwise modify their Clinical Privileges may be granted such augmentation or modification upon the Member's, APP's, AHP's demonstration that they possess the requisite training, skill, and experience necessary to competently exercise the Clinical Privileges sought.

B. Requests for additional Clinical Privileges may be made at any time. The request shall be made in writing on the appropriate Privilege form. The request shall state in detail the specific additional Clinical Privileges desired and the applicant's relevant recent training and experience which justify increased Privileges. The request for additional Privileges will be processed in the same manner as an initial application. Each applicant agrees to the same conditions outlined for initial applications in accordance with the Medical Staff Documents.

C. The Medical Executive Committee will require Initial FPPE for any additional Clinical Privileges granted to current Members or APPs in accordance with Hospital policies.

D. The Medical Executive Committee may require proctoring as part of Initial FPPE for any additional requested Clinical Privilege in accordance with Hospital policies. This requirement will be based upon the complexity of the subject procedure, risks involved, and similarity or dissimilarity to procedures for which the Practitioner is currently privileged.
   The Hospital will query the National Practitioner Data Bank for requests for additional Clinical Privileges.

4.3. TEMPORARY PRIVILEGES

A. **General**
   Under certain circumstances, Temporary Privileges may be granted for a limited period of time. The Medical Staff must review the qualifications of any Practitioner who requests Temporary Privileges and assure that the available information supports the granting of the Temporary Privileges. The nature of the Medical Staff review of an application for Temporary Privileges may vary, depending upon the reason for Temporary Privileges and the specific Privileges the Practitioner requests. Temporary Privileges may be granted under the following circumstances:

1. To fulfill an important patient care, treatment, or service need as evidenced by a written request from the applicable Chief of Service certifying that the Hospital is in immediate need of a certain applicant's services in order to render medical care to patients who cannot reasonably cared for at the Hospital by any other physician ("Patient Need"); or
2. When an applicant for new Privileges, including an application for initial Medical Staff Membership and a request for new Privileges from an existing member of the Medical Staff, with a completed application that raises no concerns, has been reviewed by the Credentials Committee, and is awaiting review and approval by the Medical Executive Committee and the Board ("Completed Application").

B. **Minimum Requirements for Temporary Privileges for Patient Need**

1. A Practitioner who requests Temporary Privileges to fulfill an important Patient Need as defined above, must satisfy the following qualifications and requirements:
    a. Complete an Application for Temporary Privileges documenting the important patient care, treatment and service need, and provide information regarding the applicant's qualifications and certify the applicant's agreement to be bound by the Medical Staff Documents, and Hospital policies and procedures.
    b. Have evidence of a current, unencumbered professional license to practice in the applicant's specialty in the state of Kansas.
    c. Have and continuously maintain professional liability insurance coverage, including prior acts coverage for claims made policies that meet the criteria specified by the Board.
    d. Have evidence of current, unrestricted federal and state prescribing authority for controlled substances if related to the temporary privileges requested.
    e. Not be currently excluded or suspended from participation in any federal health care program, including the Medicare, Medicaid, and any other government-sponsored health program.
    f. The Hospital will query and evaluate the National Practitioner Data Bank (NPDB) information regarding the applicant.

C. **Minimum Requirements for Temporary Privileges for Completed Application**

1. A Practitioner who requests Temporary Privileges while awaiting review and approval of a completed application for new Appointment and/or Privileges by the Medical Executive Committee and the Board under Article4, must satisfy the qualifications and requirements set forth in Subsection Band the following qualifications and requirements:
    a. The applicant's application for Clinical Privileges is complete, has been completely processed in accordance with the Credentialing Policy, and is awaiting action by the Medical Executive Committee;
    b. Neither the applicant's application, the materials submitted in support thereof, nor the information generated by the processing of the Application

and supporting materials pursuant to the Credentialing Policy contain any discrepancy or any information that would require further investigation before the application is approved.

c. For Practitioners, demonstrate proof of graduation from an appropriately accredited professional school and completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), American Dental Association, or American Podiatric Medical Association (APMA) approved residency program.

d. Not have been subject to a successful challenge to their licensure or registration.

e. Not have been involuntarily dismissed, terminated, or summarily suspended from any medical staff or had Privileges involuntarily terminated, restricted or summarily suspended by any health facility for reasons of clinical competence or professional conduct, which action was upheld following waiver or exhaustion of any procedural remedies which was reported to the NPDB within the past five (5) years.

f. Not have voluntarily resigned or surrendered medical staff Membership or Clinical Privileges or failed to renew Membership or Clinical Privileges while under investigation or to avoid investigation or other Peer Review activity by any health facility, which was re-ported to the NPDB within the past five (5) years.

D. **Conditions and Authority for Granting Temporary Privileges**
Provided the applicant strictly meets the criteria for Temporary Privileges specified in this Article, temporary privileges may be granted to the applicant by at least two members of the Board on the recommendation of the Chief Executive Officer (or designee), for a period not to exceed the maximum period specified in this Section.

No applicant to whom Temporary Privileges are granted shall exercise said temporary Clinical Privileges until they have received a written notice of the granting of such from the Chief of Staff.

All applicants granted Temporary Privileges shall be subject to the supervision of the Chief of Staff (or designee) and shall submit to any personal supervision and/or proctoring deemed necessary by the Chief of Staff, the Chief Executive Officer of the Hospital, or the Board. Such special conditions do not entitle the individual to any procedural rights afforded under Article 8.

Temporary Privileges shall be granted for a maximum period of ninety (90) days or until the applicant's application is approved by the Medical Executive Committee, whichever period is shorter, and shall expire automatically at the end of said period.

E. **Termination of Temporary Privileges**
The Chief of Staff or the Chief Executive Officer (or designee) may, upon written notice to the applicant, immediately revoke the applicant's Temporary Privileges if either determines that the applicant no longer meets the criteria set forth in the Credentialing Policy or Medical Staff Bylaws or if the applicant fails to comply with any supervision or reporting requirements

imposed in connection with such Temporary Privileges pursuant to the Credentialing Policy or Medical Staff Bylaws. Such revocation of Temporary Privileges shall not serve to interrupt the processing of the applicant's application for initial appointment to the Medical Staff nor shall such revocation of Temporary Privileges entitle the individual to the procedural rights afforded under Article 8 of these Bylaws.

F. **Rights of the Individual with Temporary Privileges**
The individual holding Temporary Privileges does not have the rights of a Medical Staff Member or other individual holding Clinical Privileges and will not participate in Medical Staff or Hospital Committees except as requested and may not vote. Such individuals may assume Emergency Department call responsibilities if requested by the individual and approved by the Chief of Service (or designee). Should Temporary Privileges be denied, or modified, the Practitioner will not be entitled to the procedural rights afforded under these Medical Staff Bylaws.

4.4. EMERGENCY PRIVILEGES

A. In an emergency, any individual granted Clinical Privileges, as well as any Practitioner who is not a Member of the Medical Staff, to the degree permitted by such individual's license and regardless of Medical Staff Membership or Clinical Privileges, may be permitted to do, and shall be assisted in doing, everything possible to save the life of a patient in the Hospital, using every facility of the Hospital necessary, including calling for any consultation necessary or desirable. When the emergency situation no longer exists, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition which could result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and in which any delay in administering treatment would add to that danger.

B. Emergency Specialized Care Not Available at Hospital.

    1. If there is a need for emergency specialized care not normally available at the Hospital, any Practitioner who is not credentialed at the Hospital, but possesses the skills and expertise to administer such treatment to a patient in immediate danger, may request to do everything possible to save the life of the patient.
    2. To the extent possible under the circumstances and as time and capacity permit, the Medical Staff Office will obtain verification of the emergency Practitioner's identification and current license to practice prior to the exercise of Emergency Privileges by a Practitioner not credentialed at the Hospital. In the event verification cannot be completed prior to the exercise of such emergency Privileges, such verification will be completed as soon as possible.
    3. The Practitioner's request for emergency Privileges to treat a patient in immediate danger may be approved by two (2) of the following individuals or their respective designees:
        a. The Chief Executive Officer,
        b. The Chief of Staff,
        c. The Chief Medical Officer,
        d. The applicable Chief of Service, or

e. The Chair of the Board.

4.5. DISASTER PRIVILEGES

A. Upon activation of the Hospital's Emergency Management Plan and the determination that the immediate needs of patients cannot be met by current Medical Staff Members and Hospital staff, temporary Disaster Privileges may be granted by the Chief Executive Officer (or designee) or Chief of Staff (or designee) to an individual(s) who otherwise does not hold Clinical Privileges at the Hospital upon presentation of a valid government-issued photo identification card issued by a state or federal agency (*e.g.,* driver's license or passport) and at least one of the following:

1. a current picture hospital ID card that clearly identifies the individual's professional designation;
2. a current Kansas license, certification or registration as required to practice the individual's profession (primary source verification shall be undertaken as soon as the immediate situation is under control and such verification shall be completed within seventy-two (72) hours of the request for disaster privileges or as soon as possible given the disaster situation);
3. identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other state or federal organization or group;
4. identification indicating the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or
5. identification by a current Medical Staff Member or Hospital staff member/employee who possesses personal knowledge regarding the individual's ability to act as a Licensed Practitioner during a disaster.

B. Prior to the grant of Disaster Privileges, the individual so requesting them shall, to the extent possible under the circumstances, complete forms provided by the Medical Staff Office in accordance with the applicable Medical Staff policy. The individual granted Disaster Privileges shall be assigned to a Medical Staff Member who shall assume responsibility for monitoring and evaluating the care and treatment provided by such individual in accordance with Medical Staff and Hospital policies and procedures.

C. Disaster Privileges initially shall be granted for no longer than seventy-two (72) hours, at which time the Chief Executive Officer (or designee) or the Chief of Staff (or designee) shall recommend continuation of such disaster privileges based on information obtained regarding the individual's professional practice during the disaster or through primary source verification. In the event information regarding the individual's professional performance/licensure results in adverse or unsubstantiated information about the qualifications of the individual, Disaster Privileges shall be immediately terminated by the Chief of Staff (or designee) or Chief Executive Officer (or designee). Disaster Privileges otherwise expire when the disaster situation no longer exists or when care and treatment may be adequately provided by Medical Staff Members and/or Hospital staff.

D. The Hospital will, to the extent possible, query the National Practitioner Data Bank.

E. If primary source verification of the individual's licensure cannot be completed within seventy-two (72) hours, there shall be documentation reflecting why such verification could not be completed, evidence of the individual's demonstrated ability to continue to provide care, treatment and services, and the attempts made to rectify the lack of verification.

F. If the need for Disaster Privileges extends beyond the immediate disaster response period, the individual shall apply for and be considered for Temporary Privileges in accordance with the process described in Section 4.3.

G. Notwithstanding any provision in the Medical Staff Documents to the contrary, during a mass disaster, any individual granted Clinical Privileges is authorized to intervene to provide patient care, treatment and services to the extent necessary as a life-saving measure or to prevent serious harm in accordance with the circumstances and conditions described in Section 4.4 regarding emergency privileges.

H. Termination of Disaster Privileges

1. Disaster Privileges may be terminated at any time for any reason or cause.
2. An individual's Disaster Privileges will be immediately rescinded by the CEO, the Chief of Staff, or their designee in the event any information is received that suggests the individual is not capable of rendering services in an emergency.
3. Disaster Privileges will automatically terminate when they are determined to no longer be necessary by the Chief Executive Officer, the Chief of Staff, or their designee in accordance with the Hospital Emergency Management Plan.
4. ID badges previously issued to the individual will be collected upon termination. The individual should be debriefed as time permits.
5. There will be no appeal or procedural rights under the Medical Staff Documents in the event an individual's Disaster Privileges are denied or terminated, regardless of the reason for the action.

4.6 TELEMEDICINE PRIVILEGES

The individual Practitioners, APPs, and AHPs providing Telemedicine Services must be granted appropriate Clinical Privileges by the Hospital.

A. Telemedicine Platform Privileges Included.

1. The grant of Clinical Privileges to Practitioners, APPs, and AHPs is deemed to include the right to exercise such Clinical Privileges using those telemedicine platforms available at the Hospital and approved for such internal use, and as consistent with the Practitioner's, APP's, or AHP's licensure. The clinical Services for which internal use of available telemedicine platforms will be approved by the Medical Executive Committee, in consultation with the applicable Chief of Service, and Hospital administration.

B. Privileges for Distant-Site Telemedicine Providers.
If the Hospital enters into an agreement for Telemedicine Services with an individual Practitioner or APP, then the Practitioner or APP must apply for and be granted appropriate

Clinical Privileges in the manner outlined for Members of the Medical Staff in as set forth in these Bylaws.

C. Proxy Credentialing

1. If the Hospital enters into an agreement for Telemedicine Services with a Distant-Site, as an alternative to the credentialing and privileging process set forth above, the Hospital may accept the credentialing and privileging performed by the Distant-Site, as applicable, as its own, provided that:
    a. There is a written agreement between the Hospital and the Distant-Site, as applicable, that provides written assurances to the Hospital that the Distant-Site's credentialing and privileging process and standards meet the Medicare Conditions of Participation;
    b. The Distant Site Practitioner or APP is privileged at the Distant-Site, as applicable, for those Telemedicine Services to be furnished for the Hospital, and the Distant-Site provides a copy of the Clinical Privileges held by each applicable Practitioner or APP;
    c. The Hospital will query the National Practitioner Data Bank; and
    d. The Hospital shares with the Distant-Site, consistent with confidentiality policies and applicable State law, the Hospital's performance review data of the Distant Site Practitioner or APP. At a minimum, the performance review information must include all adverse outcomes relating to sentinel events (as defined by The Joint Commission) resulting from the Telemedicine Services provided by the Distant Site Practitioner or APP and any registered complaints about the Distant Site Practitioner or APP from a patient, other Practitioner, APP, or Hospital staff.

D. Reliance on Distant-Site Credentialing Information

1. If the Hospital has an agreement for Telemedicine Services with a Distant-Site, as an alternative to the credentialing and privileging process described above, the Hospital may rely on the credentialing information furnished by the Distant-Site with whom the Hospital has an agreement for Telemedicine Services.
2. Applicants based at a Distant-Site who intend to provide Telemedicine Services under a written agreement with the Hospital under this Section must submit an application as directed by the Medical Staff Office.
3. The Hospital will query the National Practitioner Data Bank.
4. The Medical Staff Office, the Chief Medical Officer, the Medical Executive Committee, or the Board may request any additional information in accordance with Article 3 before making a recommendation to the Board.
5. In all cases, the Distant-Site Practitioner or APP must hold a current medical or professional license issued or recognized by the State of Kansas;
6. In all cases review of the application for Telemedicine Clinical Privileges by the Medical Executive Committee and the Medical Staff, and approval by the Board will follow the same procedure outlined in Article 3 above.
7. If the Hospital has not entered into a written agreement for Telemedicine Services

with a Distant Site , but the Hospital has a pressing clinical need for Telemedicine Services and a Distant Site Practitioner or APP can supply such services via Telemedicine, the Distant Site Practitioner or APP may be granted Temporary Privileges to provide Telemedicine Services for a limited time in accordance with Section 4.3.

E. In all cases, the individual performing Telemedicine Services shall be subject to and cooperate with the Hospital's processes for monitoring and evaluating the services provided under the agreement. In all cases, the individual performing Telemedicine Services shall not hold appointment to the Medical Staff and shall not be entitled to the rights and prerogatives such Membership avails. The Hospital may terminate the individual's services in accordance with the agreement and the individual is not entitled to any of the procedural rights afforded under Article 8 of these Bylaws.

F. When alternative methods of proxy credentialing or reliance on credentialing information as set forth in this Section cannot be satisfied, the individual seeking to provide only interpretive services through a telemedicine link from a distant site shall be credentialed and privileged through the processes described in the Medical Staff Documents.

G. Applicants seeking Medical Staff appointment or Clinical Privileges in addition to the privilege to perform Telemedicine Services shall be credentialed and/or privileged through the processes described in the Medical Staff Documents.

4.7. HISTORY AND PHYSICAL EXAMINATION

A. A medical history and physical examination will be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services in accordance with the Rules and Regulations and hospital policies on medical record documentation.

B. A history and physical examination must be dictated or documented in the medical record by the patient's attending physician, a credentialed Advanced Registered Nurse Practitioner (ARNP) or a Physician Assistant (PA), all under the attending physician's supervision. The history and physical must be available in the patient medical record on all inpatients within twenty-four (24) hours of admission and on all patients prior to surgery or procedure. The history and physical examination shall be countersigned by the attending physician.

C. The history and physical examination completed before admission is valid for thirty (30) days only, and must be updated with any changes (or state that no changes have occurred) within twenty-four (24) hours after admission, and prior to a surgery or procedure. The update must be documented in the medical record. A history or physical examination greater than thirty (30) days old cannot be updated, or referred to, in a current history and physical examination.

4.8. BASIS FOR PRIVILEGE DETERMINATIONS

A. **General**
Applications and requests for Clinical Privileges shall be evaluated in accordance with the process described in these Bylaws, and on the basis of the applicant's education, training, current competence, the ability to perform the Clinical Privileges requested, professional references, information from the applicant's current and past facility affiliations, professional

liability experience and insurance coverage, and other relevant information, including performance profile information, and an evaluation by the Service Chair of the Service in which the privileges have been sought. Individuals with delineated Clinical Privileges are required to participate in continuing education as related to their privileges, and the applicant's participation in continuing education shall be considered when renewing or revising such privileges. The criteria for granting Clinical Privileges shall also include the ability of the Hospital to provide supportive services for the applicant and the applicant's patients, the geographic location of the applicant, the patient care need for the requested privilege, and alternate coverage available during the applicant's absence.

Additionally, in considering any request for Clinical Privileges, the Hospital, including any Committee of the Medical Staff or the Hospital, or the Board at its discretion, may obtain assistance with such evaluation, as provided for in these Bylaws.

B. **Special Considerations for Dental, Podiatric, and AHP Privileges**
Clinical Privilege requests received from dentists, podiatrists, and Allied Health Professionals shall be reviewed in accordance with these Medical Staff Bylaws and the Medical Staff Documents. Additional special considerations regarding the Clinical Privileges granted to dentists, podiatrists, Advanced Practice Providers, and Allied Health Professionals are set forth in Section 2.1 of the Credentialing Policy.

4.9. REQUEST FOR UNAVAILABLE PRIVILEGES

Notwithstanding any other provisions of the Medical Staff Documents, if an application is made for a Clinical Privilege not available at the Hospital, such application shall not be processed and the individual submitting the application so notified. Because the basis for declining to process the application is unrelated to the requesting individual's qualifications or clinical competence, the individual shall not be entitled to the procedural rights described in Article 8.

ARTICLE 5: MEDICAL STAFF GOVERNANCE, STRUCTURE, AND FUNCTIONS

5.1 OFFICERS OF THE MEDICAL STAFF

A. Elected Officers
The officers of the Medical Staff shall include the Chief of Staff, the Vice Chief of Staff, the Secretary-Treasurer and the Immediate Past Chief of Staff.

B. Qualifications
Officers must be members of the Active Staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office. Failure to maintain such status shall immediately create a vacancy in the position. No Member of the Medical Staff, actively practicing at the Hospital, is ineligible for election to an Officer position solely because of the Member's professional discipline, specialty, or practice as a hospital-based physician.

C. Term of Office and Eligibility for Re-Election
Each Officer shall serve a two (2) year term with the exception of the Secretary-Treasurer who

shall serve a one (1) year term. The term of office shall commence on the first day of the medical staff year following the election. Each Officer shall serve in office until the end of their term or until a qualified successor is duly elected, unless the Officer resigns, or is removed or recalled from office, or is otherwise unable to complete the term. At the end of the Chief of Staff's term, the Immediate Past Chief of Staff shall retire, the Chief of Staff shall automatically assume the office of Immediate Past Chief of Staff, and the Vice Chief of Staff shall automatically assume the office of Chief of Staff. At the conclusion of the term, the current Secretary-Treasurer shall retire and the position filled in accordance with the nomination and election process described in this Section.

D. Nomination

In sufficient time prior to the annual Staff meeting the Nominating Committee shall convene and submit to the Medical Executive Committee one or more qualified nominees for the office of Secretary-Treasurer each year and Vice Chief of Staff every two years. The Medical Executive Committee shall report to the Staff, by posting or other communication, the names of the nominees at least thirty (30) days before the annual Staff meeting.

Nominations of qualified candidates may also be made by petition signed by at least ten percent of the Staff eligible to vote, with an attestation of willingness to serve from the nominee(s), filed with the Chief of Staff or the Medical Staff Office at least thirty (30) days before the annual Staff meeting. As soon as thereafter reasonably possible, the names of the additional nominee(s) shall be reported to the Staff, by posting or other communication. If, prior to the election, all of the additional nominee(s) refuse or are disqualified or are otherwise unable to accept nomination, nominations may be accepted from the floor at the annual Staff meeting if the nominee is present at the meeting, meets the qualifications of an Officer of the Staff, and consents to nomination.

E. Election

Only Active Medical Staff Members shall be eligible to vote. A quorum shall consist of fifty (50) percent of those eligible to vote and present at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receipt of a majority of the valid votes cast. If no candidate receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The election shall become effective upon approval of the Board.

F. Vacancies

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall of an officer, or upon the officer's failure to maintain Active status in good standing. Vacancies shall be filled in the following manner:

1. Chief of Staff

   When a vacancy occurs in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remaining term of the former Chief of Staff. The vacancy then created in the office of the Vice Chief of Staff shall be filled as outlined in this section.

   In the event of the simultaneous vacancies in the offices of Chief of Staff and Vice Chief of Staff, the Board upon recommendation of Medical Executive Committee, shall appoint Interim Officers to fill the vacant positions and a special general election shall then be conducted within ninety (90) days of such appointments, in

accordance with the nomination and election procedures described in these Bylaws. The term of the Interim Officers shall be designated on the voting slate.

2. Vice Chief of Staff
   When a vacancy occurs in the office of the Vice Chief of Staff, the position shall be filled by majority vote of the Medical Executive Committee, with confirmation by the Board, if the vacancy occurs during the medical staff year. The individual so selected shall serve as Vice Chief of Staff until such vacancy can be filled by general election following nomination, as provided in Section 5.1.

3. Secretary-Treasurer
   When a vacancy occurs in the office of the Secretary-Treasurer, the vacancy shall be filled by majority vote of the Medical Executive Committee, with confirmation by the Board, if the vacancy occurs during the medical staff year. The individual so selected shall serve as Secretary-Treasurer until such vacancy can be filled by general election following nomination, as provided in Section 5.1.

G. Resignation, Removal and Recall from Office

1. Resignation
   Resignation of an Officer shall occur upon written notice of such to the Medical Executive Committee which must formally accept the resignation before it is effective.

2. Removal
   An Officer may be removed from office for cause. Removal shall occur upon majority vote of the Medical Executive Committee with approval by the Board, or with the majority vote of the Board. Grounds for removal include but are not limited to the following:

   a. Failure to perform the duties of the office.
   b. Failure to comply with/support/enforce the Medical Staff Documents and Hospital policies/procedures.
   c. Failure to comply with and/or support the compliance by the Hospital and the Medical Staff with applicable federal, state, and local laws/regulations, and the standards of any regulatory or accrediting body with jurisdiction over the Hospital.
   d. Failure to maintain the qualifications for office.
   e. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or Medical Staff.

3. Recall from Office
   An Officer may be recalled from office for cause. Recall of an Officer may be initiated by a majority vote of the Medical Executive Committee or by a petition signed by at least ten (10) percent of the Members eligible to vote. Recall shall be considered by the Medical Staff at a regular meeting or a special meeting called for such purpose with notice of the recall consideration given to Members as provided in Section 5.2. A quorum shall consist of all those present who are eligible to vote. Recall of an Officer shall require a two-thirds (2/3) majority of the quorum. Voting by proxy shall

not be permitted. The recall shall become effective upon approval by the Board.

H. Responsibilities and Authority of Officers

1. Chief of Staff
   The Chief of Staff shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the Chief of Staff are to:

   a. call, preside at, and be responsible for the agenda and accurate record of all general and special meetings of the Medical Staff;

   b. serve as chairperson of the Medical Executive Committee and call, preside at, and be responsible for the agenda and accurate record of all meetings thereof;

   c. serve on Hospital and Medical Staff Committees as assigned and as an ex-officio member of all other Medical Staff committees without vote, unless otherwise specified;

   d. appoint the chairpersons and Members of all Medical Staff standing and ad hoc committees in accordance with these Bylaws, except when such chairmanships and Memberships are designed by position or by specific direction of the Board;

   e. be accountable and responsible for and report to the Board regarding the quality and efficiency of patient care services as provided by the Medical Staff and individuals with Clinical Privileges;

   f. be responsible for the enforcement of the Medical Staff Documents, implementation of sanctions where indicated, and for the Medical Staff's compliance with Article 8 and/or other procedural safeguards in all instances where a professional review action has been recommended or taken against a Member or individual with Clinical Privileges;

   g. communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Chief of Staff/Chief Executive Officer and the Board, and serve as an ex-officio member of the Board;

   h. receive and interpret the opinions, policies, and directives of Hospital Administration and the Board to the Medical Staff;

   i. act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory/ accrediting agencies in external professional and public relations;

   j. ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and

   k. perform all other functions as may be assigned in accordance with these Bylaws, by the Medical Staff; the Medical Executive Committee or by the Board.

2. Vice Chief of Staff
   In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the

duties and have the authority of the Chief of Staff; shall serve on Committees and accept such responsibilities as assigned or in accordance with the Medical Staff Documents, or by the Chief of Staff of the Medical Staff or the Board; shall automatically succeed the Chief of Staff when the latter fails to complete their term of office for any reason and at the expiration of the Chief of Staff's term; and, shall be responsible for all other duties as assigned.

3. Secretary-Treasurer
   The Secretary-Treasurer shall be responsible for accounting, record-keeping and safeguarding of funds of the Medical Staff, and performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Medical Staff Chief of Staff, Medical Executive Committee or the Board.
4. Immediate Past Chief of Staff
   Although the duties of the Immediate Past Chief of Staff are primarily advisory in nature, the Immediate Past Chief of Staff shall serve on Committees and accept such responsibilities as may be assigned to him/her or in accordance with the Medical Staff Documents, or by the Chief of Staff of the Medical Staff, the Medical Executive Committee, or the Board.

5.2. MEETINGS OF THE GENERAL MEDICAL STAFF

A. Regular Meetings
   The Medical Staff shall meet at least annually and notice of such shall be provided to Members at least fourteen (14) days in advance of the meeting by posting in a location(s) at the Hospital frequented by and conspicuous to Members, or as otherwise specified in these Bylaws. The Chief of Staff and other Officers of the Medical Staff, Hospital representatives and Committee Chairpersons, or their designees, shall present reports on matters of interest, importance and responsibility of the Members, as appropriate. Election of Officers, Chief of Services and certain members of Medical Staff Committees as specified in these Bylaws shall occur at the annual meeting of the Medical Staff. The Chief of Staff of the Medical Staff shall designate the date, time and place for all regular meetings of the Medical Staff.

B. Special Meetings
   Special meetings of the Medical Staff may be called at any time by the Medical Staff Chief of Staff, the Medical Executive Committee, the Board, or upon the written request of at least ten (10) percent of the Active Medical Staff. The individual calling or requesting the special meeting shall state the purpose of such special meeting in a written notice to the Chief of Staff of the Medical Staff. The meeting shall be scheduled by the Chief of Staff and posted to Members within fourteen (14) days after receiving such written request, in a location(s) at the Hospital frequented by and conspicuous to Members, or as otherwise specified in these Bylaws. No business shall be transacted at any special meeting except as stated in the notice of the meeting.

C. Notice of Meetings
   Written or printed notice of regular or any special meeting of the Medical Staff shall state the place, date, and hour of the meeting and shall be posted in a location(s) at the Hospital frequented by and conspicuous to Members no less than ten (10) days prior to the meeting, or as otherwise specified in the Medical Staff Documents. Exceptions may be granted by the Medical Executive Committee if an urgent matter prompted the meeting. Notice of meetings

may also be made by mail, facsimile, and or electronic mail to the mailing, facsimile or internet address provided to the Hospital by the Member and such notice of the meeting shall be deemed delivered at the time of the sending. The attendance of a Member at a meeting shall constitute waiver of notice of such meeting.

D. Minutes of Meetings
Accurate minutes of each meeting of the Medical Staff shall be the responsibility of the Medical Staff Chief of Staff, shall include a record of the attendance, and shall document the business conducted and the action(s) taken. Copies of the minutes shall be submitted for approval to all attendees eligible to vote at the next meeting of the Medical Staff.

E. Quorum
Quorum requirement for any Annual or Special Meeting is defined as those voting Medical Staff members present or those voting Medical Staff Members participating by returning a response within the timeframe specified to a vote presented via e-mail, electronic voting mechanism, telephone, videoconference, or other remote voting method as determined by the Chief of Staff. In the event that a vote is required regarding the removal of an officer, a majority of the Active staff must be present or participate in the vote.

5.3. CLINICAL SERVICES

The Medical Staff shall be organized into clinical services based on practice specialty. The Medical Executive Committee may create, eliminate, further subdivide, combine or otherwise modify the clinical Services, subject to approval of the Board, based on the evolving scope of healthcare services provided by the Hospital and the need for effective Medical Staff oversight and to support quality patient care. Since the primary function of a clinical Service is responsibility for the quality of patient care provided by the Members of the Service, the primary incentive for modifying a Service shall be whether the Service has a sufficient number of Active Staff Members and sufficient patient volumes to support the performance improvement activities, including monitoring and evaluation responsibilities, required of a Service.

The Clinical Services include Medicine, Surgery and Obstetrics/Pediatrics. Each Service is directed by a Chief of Service who is a member of and responsible to the Medical Executive Committee.

A. **Service Affiliation Requirements**
Each Medical Staff Member and other individuals with Clinical Privileges shall be assigned to one Service by the Board based on recommendation from the Medical Executive Committee. A Member or other individual with Clinical Privileges may be granted such privileges in one or more of the other Services. The exercise of Clinical Privileges within any Service shall be subject to Medical Staff Documents and any standards of the Service under the authority of the Chief of Service.

B. **Functions of Service**
The Service, under the direction of the Chief of Service, shall be responsible for the quality of care provided by members of the Service; compliance by members of the Service with the Medical Staff Documents; and, fostering an atmosphere of professional decorum within the Service appropriate to the practice of medicine.

5.4. CHIEF OF SERVICE

A. Qualifications
Each Chief of Service shall be qualified for the position by training, experience and demonstrated competence. The Chief of Service shall be certified by a certifying Board approved by the Board of Directors and be a member of the Service to which they have been elected Chief. Each Chief of Service shall be a member of the Active Medical Staff at the time of nomination, election and ratification, and shall remain a Member in good standing throughout the Chief of Service's elected term.

B. Nomination
In sufficient time prior to the annual Staff meeting the Nominating Committee shall convene and submit to the Medical Executive Committee one or more qualified nominees for the Chief of Service. The Medical Executive Committee shall report to the Staff, by posting or other communication, the names of the nominees at least forty-five (45) days before the annual Staff meeting.

Nominations of qualified candidates may also be made by petition signed by at least ten (10) percent of the Staff eligible to vote, with an attestation of willingness to serve from the nominee(s), filed with the Chief of Staff or the Medical Staff Office at least thirty (30) days before the annual Staff meeting. As soon as thereafter reasonably possible, the names of the additional nominee(s) shall be reported to the Staff, by posting or other communication. If, prior to the election, all of the additional nominee(s) refuse or are disqualified or are otherwise unable to accept nomination, nominations may be accepted from the floor at the annual Staff meeting if the nominee is present at the meeting, meets the qualifications of Chief of Service, and consents to nomination.

C. Election and Tenure

1. Only Active Medical Staff Members shall be eligible to vote. A quorum shall consist of fifty (50) percent of those eligible to vote and present at the meeting or participate in the vote. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The election shall become effective upon approval of the Board.
2. Each Chief shall take office on the first day of the Medical Staff year following ratification by the Board, and shall serve a two (2) year term.
3. Removal of a Chief of Service shall occur automatically if there is automatic termination of the Chief of Service's Medical Staff Membership, as triggered by any of the conditions expressed in the Medical Staff Documents. Removal for cause may occur upon majority vote of the Medical Executive Committee with approval by the Board, or upon majority vote of the Board. Grounds for removal for cause may include any one or more of the following, without limitation:
    a. failure to perform those responsibilities of the position;
    b. failure to comply with or support the enforcement of the Medical Staff

Documents and/or Hospital policies and procedures;

c. failure to comply with and/or support the compliance of the Hospital and the Medical Staff to applicable federal and state laws and regulations and the standards and other requirements of accrediting agencies with jurisdiction over the Hospital or any of its clinical services;

d. failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or

e. failure to adhere to professional ethics or any other action deemed to be injurious to the reputation of, or inconsistent with the best interests of the Medical Staff or Hospital.

4. Resignation of the Chief of Service position shall occur upon written notice of such to the Medical Executive Committee which must formally accept the resignation before it is effective.

5. Any unexpected vacancy in the Chief of Service position may be filled by advancing the Vice Chief of Service into the vacant position with replacement of the Vice Chief of Service position by Medical Executive Committee appointment, or, at the discretion of the Medical Executive Committee, it may elect to appoint a replacement to serve as the Chief of Service. Under any of the alternatives, the individual so appointed shall serve in the position.

D. Responsibilities

The responsibilities of the Chief of Service include but are not limited to the following:

1. maintain accountability for all clinically related and administrative activities of the Service, unless otherwise provided by the Hospital;

2. serve as a member of the Medical Executive Committee, providing suggestions and guidance regarding Medical Staff Rules and Regulations and Hospital policies and making recommendations regarding the represented Service to promote quality patient care;

3. maintain accountability for the ongoing surveillance of professional performance of all members of the Service granted Clinical Privileges;

4. recommend to the medical staff within the Service the criteria for Clinical Privileges relevant to care provided within the Service;

5. provide written recommendations to the Credentials and Medical Executive Committees concerning the appointment, reappointment, assignment of Staff category, and delineation of Clinical Privileges for Service members;

6. assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Service or the Hospital;

7. integrate the Service into the primary functions of the Hospital collaborating with Hospital Administration, Nursing Services and other Services regarding matters affecting patient care;

8. coordinate and integrate interdepartmental and intradepartmental service;

9. develop and implement policies and procedures that guide and support the provision of care, treatment and services;
10. recommend sufficient numbers of qualified and competent persons to provide care, treatment and services;
11. determine the qualifications and competence of Service personnel who are not licensed independent practitioners and who provide patient care services;
12. on an ongoing basis, assess and improve the quality of care, treatment and services;
13. maintain quality control programs, as appropriate;
14. orientation and continuing education of all persons in the Service;
15. recommend space and resources needed for privileges granted or requested;
16. assume responsibility for enforcement, within the Service, of the Medical Staff Documents as well as applicable Hospital policies and procedures, including the Corporate Compliance Plan;
17. assume responsibility for implementation, within the Service, of actions taken by the Board, the Medical Executive Committee and other Medical Staff and Hospital Committees;
18. assume oversight responsibility for education and research initiatives within the Service;
19. assist in the preparation of annual reports, including budgetary planning pertaining to the Service, as may be required by the Medical Executive Committee, the Chief of Staff/Chief Executive Officer or the Board;
20. communicate and disseminate to Service members relevant information and directives from the Medical Executive Committee and Hospital Administration.

5.5. FUNCTIONS OF THE MEDICAL STAFF

A. **Governance**

Although the Medical Staff is an integral part of the Hospital and is not a separate legal entity, it is organized to perform its required functions. The Medical Staff organization shall:

1. Establish a framework for self-governance of Medical Staff activities and accountability to the Board as described in the Medical Staff Documents.
2. Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.
3. Have the authority to develop, amend and adopt Medical Staff Documents subject to Board approval, or delegate such authority to the Medical Executive Committee as described in these Bylaws.

B. **Planning**

The leaders of the Hospital include members of the Board, the Chief Executive Officer and other senior executives, Hospital Department leaders, and elected and appointed leaders of the Medical Staff and other Medical Staff members who hold medico-administrative positions.

Medical Staff leaders shall participate in the performance of the following Hospital planning activities:

1. planning patient care services;
2. planning and prioritizing performance improvement activities;
3. budgeting;
4. providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated privileges, within the Medical Staff Office, across Services, and between members and non-members of the Medical Staff who have delineated Clinical Privileges;
5. recruitment, retention, development and continuing education of all staff; and
6. consideration of and implementation of clinical practice guidelines as appropriate to the patient population.

C. **Credentialing**

The Medical Staff is fully responsible to the Board for the credentialing process, which includes activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of Clinical Privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

1. establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff Membership, and for granting delineated Clinical Privileges to qualified applicants, as detailed in Articles 3 and 4 of these Bylaws;
2. establish professional criteria for Membership and for Clinical Privileges;
3. conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff Membership or Clinical Privileges;
4. submit recommendations to the Board regarding qualifications of an applicant for appointment, reappointment or Clinical Privileges;
5. establish a mechanism for Fair Hearing and Appellate Review; and
6. establish a mechanism to ensure that the scope of practice of individuals with Clinical Privileges is limited to the Clinical Privileges granted.

D. **Performance Improvement Activities**

1. *General Responsibilities*

   The Board requires the Medical Staff be accountable to it for the quality of care provided to patients. All Medical Staff members and all others with delineated Clinical Privileges shall be subject to periodic performance review and appraisal as part of the Hospital's performance improvement activities, as described in the Performance Improvement, Patient Safety and Risk Management Plans. All organized services related to patient care shall be evaluated. Through the activities of the Medical Executive Committee Peer Review/Risk Management Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform roles in performance

improvement activities, including but not limited to those listed below. The Medical Staff shall ensure that the findings, conclusions, recommendations and actions taken to improve organizational performance are communicated to the appropriate Medical Staff members.

a. The Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital's performance improvement program. The Board, the Medical Staff and Hospital Administration shall be responsible for ensuring the following:
    i. that an ongoing program of performance improvement, and patient safety, including the reduction of medical errors, is defined, implemented and maintained;
    ii. that facility-wide performance improvement efforts address priorities for improved quality of care and patient safety and satisfaction; and that all improvement actions are evaluated;
    iii. that clear expectations for safety are established; and
    iv. that adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital's performance and reducing risk to patients.

b. The Medical Staff shall perform a leadership role in the Hospital's performance improvement activities when the performance of a process is dependent primarily on the activities of one or more individuals with Clinical Privileges. Such activities shall include, but are not limited to a review of the following:
    i. medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;
    ii. use of blood and blood components, including the review of any significant transfusion reactions;
    iii. mortality and morbidity review;
    iv. use of medications;
    v. infection control and surveillance practices;
    vi. use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;
    vii. efficiency of clinical practice patterns, including the review of readmissions, appropriateness of discharge, and resource/utilization review;
    viii. significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports, and patient or staff complaints involving the Medical Staff;

ix. other indicators, as may be established by the Service or Service Section and pursuant to the organizational Performance Improvement and Risk Management Plans; and

x. use of developed criteria for autopsy.

c. The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes. Such activities shall include, but are not limited to a review of the following:

i. education of patient and families;

ii. coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient; and

iii. accurate, timely, and legible completion of patients' medical records, including the review of medical record completion delinquency rates.

d. When the findings of performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff member or holds Clinical Privileges, the Medical Staff is responsible for determining the proper application of peer review findings and the ongoing evaluations of the individual's competence. In accordance with these Bylaws, Clinical Privileges are renewed or revised accordingly.

2. *Peer Review Responsibilities*
Under Kansas law, peer review is defined by K.S.A. §65-4915 and K.S.A. §65-4923 et seq. As a general rule, peer review means the concurrent or retrospective review of an individual's professional qualifications, professional competence, or professional conduct, including such review conducted as professional review activities. Peer review or professional review activities are conducted to evaluate the quality of healthcare provided by a Member or individual holding Clinical Privileges and/or to determine whether such Member or individual may continue to hold Medical Staff Membership or Clinical Privileges, to determine the scope and conditions of such Membership or Clinical Privileges, or to change or modify such Membership or Clinical Privileges.

a. Purpose of Peer Review
The purpose of the Hospital's peer review process, as more specifically defined in Hospital policies and by K.S.A. §65-4915 and K.S.A. §65-4923 et seq. include but are not limited to the following objectives:

i. to improve the quality of health care provided to patients;

ii. to reduce morbidity and mortality at the Hospital;

iii. to perform statutory risk management functions; and

iv. to facilitate the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Medical Staff members, other individuals with Clinical Privileges, and other health care professionals who provide care to patients in the Hospital.

b. Peer Review Information
All peer review information shall be maintained on site at the Hospital and maintained in a private and confidential manner. A Medical Staff member, other individuals with Clinical Privileges, or other Hospital staff members who participates or has participated in any peer review process at the Hospital shall treat all peer review information as private, confidential and privileged. Peer review information obtained, generated or compiled during the peer review process shall not be disclosed unless specifically and expressly authorized by the Hospital's General Counsel or Chief Compliance Officer or their designee.

c. Hospital Peer Review Committees or Functions
The peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: performance improvement, utilization management, credentialing, infection control, use of medications, use of blood and blood components, risk management, quality assessment, performance improvement, resource utilization, infection control and surveillance, and Fair Hearings conducted pursuant to Article 8 of these Bylaws.

d. Records and Minutes
The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review activities shall be considered confidential and privileged. The commencement and completion of any peer review process shall be documented and any ongoing peer review activities shall be identified. Peer review records and information shall be identified with a conspicuous notation or stamp, designating its privileged and confidential status. The identities of individuals who participate in any peer review process shall be documented.

e. Credentialing Records and Files
The credentialing record or file of each Medical Staff member or other individual with Clinical Privileges shall be segregated so that the documents subject to the peer review privilege under applicable Kansas law are maintained separately and so identified.

f. Custody of Peer Review Information
Peer review information, including Medical Staff peer review records, shall be maintained in the custody of the Administrative Manager or Director of the Medical Staff Office and/or the Chief Compliance Officer.

g. Internal Access to Peer Review Information
A Medical Staff member or other individual with Clinical Privileges shall be permitted access to information in their credentials and peer review files only if, following a written request by the individual, the Chief of Staff/Chief Executive Officer, Medical Staff Chief of Staff, or Chief Compliance Officer in consultation with legal counsel, finds that the individual has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is

requested; whether the release of information might have an adverse effect on the Hospital, the Medical Staff, the requesting individual or other persons; whether the information could be obtained in a less intrusive manner; whether a harmful precedent might be established by the release; and such other factors as might be considered appropriate. The Medical Executive Committee or the Board may enforce restrictions or conditions if access is permitted.

Members of the Board, licensing agencies, accreditation and regulatory authorities, the Chief of Staff/Chief Executive Officer, counsel to the hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may access the records of committees on which they serve and the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and official functions. The Board and the Chief of Staff/Chief Executive Officer and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions. Pursuant to the Kansas peer review statute, KSA 65-4915, a peer review or risk management committee and/or peer review officer may report peer review activities, information and findings to other peer review committees or officers or to the board of directors or an administrative officer of another health care provider without waiver of the privilege. Such disclosures shall occur only through a formal process established by the respective hospital-based peer review or risk management committee.

h. External Requests for Credentials Files Information
Upon approval by the Chief Compliance Officer, the Medical Staff Office may release information contained in credentials files, as consistent with policy, in response to a proper request from another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. The request must include information that the Practitioner or other individual with Clinical Privileges is a member of the requesting facility's medical staff or has been granted privileges at the requesting facility, or is an applicant for Medical Staff Membership or Clinical Privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.

i. Reporting Obligations
If a Practitioner or other individual with Clinical Privileges has been the subject of statutory risk management activities and/or disciplinary action at the Hospital and information concerning such must be reported by law

to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes.

j. Surveyor Review
Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff records on the Hospital premises in the presence of Hospital personnel in accordance with law or accreditation requirements, provided that:

   i. no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or other legal requirements;

   ii. access is provided only with the concurrence of the Chief of Staff/Chief Executive Officer (or designee), Chief Compliance Officer, or the Medical Staff Chief of Staff (or designee); and

   iii. the surveyor demonstrates the following to the satisfaction of the grantor:

      a. specific statutory, regulatory or other appropriate authority permits or mandates review of the requested materials;

      b. the materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;

      c. the materials sought are the most direct and least intrusive means to accomplish the purpose; sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital; and

      d. if requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.

k. Subpoena
All subpoenas of Medical Staff records shall be immediately referred to the General Counsel or Chief Compliance Officer for direction regarding compliance.

l. Legal Counsel
Legal Counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.

m. Other Disclosure Requests
All other disclosure requests shall be forwarded to the General Counsel for the Hospital or Chief Compliance Officer.

n. Peer Review Meetings
All peer review functions and activities shall be performed only at

meetings held on the campus of the Hospital, unless other arrangements have been directed.

E. **Continuing Medical Education**
The Medical Staff shall provide continuing education opportunities for its Membership not less than quarterly. Continuing medical education is considered in reappointment decisions to the Medical Staff or renewal or revision of individual Clinical Privileges. The Medical Staff shall develop educational programs for Medical Staff members and others with Clinical Privileges related at least in part to the type and nature of care offered by the Hospital and the findings of performance improvement activities.

The Hospital shall also sponsor educational activities for all individuals with delineated Clinical Privileges and document each individual's participation.

Additionally, and as appropriate, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of Residents, Interns and Medical Students.

5.6. CONFLICTS OF INTEREST

A. When performing a function or responsibility described in these Bylaws or Medical Staff Documents, an applicant, Member, AHP, or APP shall disclose any actual conflict of interest or that which would reasonably be perceived as a conflict of interest or bias in any transaction, occurrence or circumstance which exists or may arise with respect to the individual's activities in Medical Staff or Allied Health Staff affairs, including Committee activities. When such conflict of interest exists or may arise, the conflicted individual shall declare the conflict and, where indicated, decline to vote on the matter. However, that individual may be asked and may answer any questions concerning the matter. This provision does not prohibit any person from voting for themself nor from acting in matters where all others who may be significantly affected by the conflict of interest consent to such action.

B. Any other individual with knowledge of such actual or perceived conflict on the part of any Member may call the existence of such to the attention of the Chief of Staff. The Chief of Staff shall have the duty to delegate the performance of the function or responsibility in question to another Member when a conflict of interest is disclosed or is reasonably perceived to exist. Medical Staff Members shall also be bound by corporate conflict of interest policies adopted by the Board to the extent such policies apply to them.

ARTICLE 6: MEDICAL STAFF COMMITTEES

6.1 GENERAL INFORMATION REGARDING MEDICAL STAFF STANDING COMMITTEES

A. Overview

1. The key functions of the Medical Staff shall be performed in an ongoing manner through the activities of the Services and Committees of the Medical Staff. Specific

key functions of the Medical Staff shall be performed through Medical Staff standing committees, ad-hoc committees, or multidisciplinary Hospital committees.

2. In addition to the Standing Committees, the Medical Executive Committee or any Officer or Chief of Service of the Medical Staff may designate a subcommittee or ad-hoc committee of any Standing Committee. If continued need for the subcommittee or ad-hoc committee is no longer indicated, the subcommittee or ad-hoc committee may be abolished upon approval of the Officer or Chief of Service who designated the Committee. A report of the Subcommittee or Ad-Hoc Committee may be requested by a Standing Committee.
3. Standing Committees of the Medical Staff are the Medical Executive Committee, the Credentials Committee, the Medical Staff Peer Review/Risk Management Committee. Additional Standing Committees of the Medical Staff are provided in the Organizational Manual. Medical Staff are also represented on multi-disciplinary Hospital Committees with specific functions and responsibilities as described in Hospital policies and other documents.
4. The leaders of the Medical Staff shall collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital Committees. When a Hospital Committee is involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital Committee shall include Medical Staff representation and participation. The Medical Staff Chief of Staff shall appoint Medical Staff representatives to a Hospital Committee with input from the Chief Executive Officer or designee.

B. Appointment of Chairperson and Members

1. Unless specified otherwise in these Bylaws, within a reasonable time period prior to the end of each Medical Staff year, the Medical Executive Committee, upon recommendation of the Medical Staff Chief of Staff, shall appoint Medical Staff members to Medical Staff Standing Committee positions. Terms of appointment shall commence at the start of the next Medical Staff year. The Chief Executive Officer, in consultation and with the approval of the Chief of Staff, shall make administrative staff appointments to Medical Staff Committees. Unless otherwise specified, such administratively appointed staff members serving on any Medical Staff Committee shall not have the right to vote.
2. The Chief Executive Officer or designee shall be an ex-officio member of all Medical Staff Committees. The Chief Executive Officer may designate another administrative or management team member to attend any meeting in the Chief Executive Officer's place. Other ex-officio members of specific Standing Committees of the Medical Staff shall be defined for each Committee.

C. Term and Vacancies

1. Unless specified otherwise in these Bylaws, the term of office for a Medical Staff Standing Committee Chairperson shall be two (2) years and that of a Standing Committee member shall also be two (2) years. Unless otherwise stated, committee members and chairs may serve for successive terms without limit.
2. If a Chairperson or member of a Standing Committee fails to maintain Medical Staff

Membership in good standing or fails to attend, participate or perform the duties of the Committee position, the Medical Staff Chief of Staff, the Medical Executive Committee, or the Board may remove that member from the Committee position. As a condition of serving on a Committee, and by virtue of having accepted the appointment, each member agrees to participate on the Committee and further agrees not to divulge any of the peer review or other confidential proceedings of the Committee. Failure to abide by the confidential requirements of such proceedings shall subject the member to removal from membership on the Committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies shall be filled in the same manner in which an original appointment to such Committee is made.

D. Meetings

1. The frequency of meetings shall be defined in writing for each Committee, and shall be appropriate to the duties and functions of the Committee. All business meetings for all Committees, Subcommittees, and Services shall be held on the campus of the Hospital.
2. Notice of Committee meetings may be given in the same manner as notice for Medical Staff meetings, but in addition, notice of a Committee meeting may be given orally but may be given not less than three (3) days before the meeting.
3. At the discretion of the committee chair, a Medical Staff committee meeting may be conducted by telephone or video conference or other reliable virtual or electronic means the committee chair deems appropriate, which shall be deemed to constitute a meeting of the committee for the matters discussed and action taken during such electronic meeting.

E. Quorum

1. A quorum shall consist of at least fifty (50) percent of the voting members of a Committee but in no event less than three (3) voting members.
2. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of voting members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws.
3. Ex-Officio non-voting committee members shall not be counted in determining the presence of a quorum.

F. Manner of Acting

1. The act of a majority of the quorum of a committee, who are present in person at a meeting or by interactive telecommunication, shall be the act of the committee.
2. At the discretion of the committee chair action may be taken without a meeting of the committee if a majority of the voting members of the committee agree to the action in writing or through a secure electronic or facsimile means, including via email, setting forth the action to be taken.

G. Action Through Subcommittees

Unless specifically delegated, a Subcommittee or Ad-Hoc Committee shall not take any action

that requires the vote of the Committee to which it reports. The Subcommittee shall submit recommendations, to be acted on by the Committee.

H. Minutes
Each Committee or Subcommittee shall record minutes of each meeting in the format specified by the Hospital and shall be recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the Committee or Subcommittee, and the Committee's or Subcommittee's findings, conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports or other materials of each committee shall be kept and maintained indefinitely at the Hospital and in accordance with its records retention policy.

I. Procedures
Each Committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or the Medical Staff Documents.

J. Reports
Each Standing and Special Committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each Subcommittee shall periodically report its activities to the Committee of which it is a part.

6.2. MEDICAL EXECUTIVE COMMITTEE

A. Composition

1. The Medical Executive Committee shall be a Standing Committee and shall consist of the Officers of the Medical Staff (Chief of Staff, Vice Chief of Staff, Secretary/Treasurer and Immediate Past Chief of Staff), the Chiefs of Service, the Chairman of the Credentials Committee, one representative each from Pathology, Anesthesiology, Emergency Medicine, Radiology, and Hospitalist elected by the Medical Executive Committee, and no more than five (5) at-large Members from the Active Medical Staff who is elected by the general Medical Staff. One or more Medical Staff members serving on the Board shall serve as an ex-officio member(s) of the Medical Executive Committee, without vote. The Chief of Staff/Chief Executive Officer of the Hospital, Chief Medical Officer, Chief Operations Officer, Chief Nursing Officer and the Chief Compliance Officer shall participate in Medical Executive Committee meeting and peer review activities in an ex-officio capacity, without vote. Chief of Services are members without a vote in regards to recommendations made by the Credentials Committee. Chief of Services may vote on all other matters brought forth to the Medical Executive Committee.
2. To the extent of its peer review responsibilities, the Medical Executive Committee shall function as a peer review committee consistent with federal and state laws. All Medical Executive Committee members shall adhere to Hospital confidentiality policies and keep in strict confidence all documents, reports, and information obtained by virtue of membership on the Committee. Closed session shall consist of all Members, invited attendees the Chief of Staff/Chief Executive Officer (or designee), Chief Medical Officer and Chief Compliance Officer. Advanced Practice Provider and Allied Health Professional members of the Medical Staff Peer Review/

Risk Management Committee may participate in an ex-officio capacity upon request of the Medical Staff Peer Review/Risk Management Chair or Medical Staff Chief of Staff.

B. Duties

1. The duties and responsibilities of the Medical Executive Committee are delegated to it by the Medical Staff and may be modified by amendment to these Bylaws in accordance with Article 11 of these Bylaws and shall include but not be limited to the following:

    a. represent and act on behalf of the Medical Staff, without requirement for subsequent approval by the Staff, subject to such limitations as may be imposed by these Bylaws;

    b. recommend to the Board the structure of the Medical Staff and the mechanism for review of credentials and delineation of Clinical Privileges, coordinate the activities of the medical staff, and implement these Bylaws, Rules, Regulations and policies that affect the Medical Staff, including the mechanism by which Medical Staff Membership may be terminated and Fair Hearing procedures;

    c. receive and act on Committee reports;

    d. serve as liaison between the Medical Staff and the Chief of Staff/Chief Executive Officer and the Board;

    e. periodically review the Medical Staff Bylaws, Rules, Regulations and policies and recommend revisions to the Medical Staff or directly to the Board if such responsibility has been delegated to the Medical Executive Committee by the Medical Staff to comply with applicable law/regulation/accreditation standards and accurately reflect the Hospital's current policies regarding Medical Staff organization and function;

    f. recommend to the Board the processes for Medical Staff performance improvement activities, as well as the mechanism used to conduct, evaluate and revise such processes;

    g. review clinical pertinence, accuracy and timely completion of medical records on a regular basis as set out in the Medical Staff Documents;

    h. review the appropriateness of patient admissions and stays at the Hospital;

    i. review processes related to medication use;

    j. fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital;

    k. review the recommendations of the Credentials Committee concerning all applications and requests for Clinical Privileges and/or Membership and make written recommendations to the Board regarding such applications, requests for Clinical Privileges and delineation of Clinical Privileges or Membership;

    l. periodically review information regarding Medical Staff appointees and

other individuals holding Clinical Privileges, including but not limited to peer review and performance profile data, and, as a result of such reviews, make recommendations for reappointments and renewal or changes to Clinical Privileges in accordance with the Policy on Appointment and Reappointment;

m. conduct and supervise Medical Staff peer review activities;

n. report at each general Medical Staff meeting regarding its activities;

o. make referrals to the Practitioner Health Committee as appropriate;

p. collaborate with Hospital leaders in planning activities;

q. take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all appointees to the Medical Staff and all individuals holding Clinical Privileges, including the initiation of and/or participation in corrective or review measures when warranted, as consistent with the Medical Staff Documents and/or Hospital policy;

r. keep the Medical Staff informed of applicable accreditation and regulatory requirements affecting the Hospital;

s. provide a mechanism by which medical staff members may request capital equipment, and to evaluate and prioritize requests prior to recommending purchases to the Chief of Staff/Chief Executive Officer; and,

t. develop an annual budget to be presented for approval at the annual meeting of the Medical Staff.

u. determines the qualifications of the radiology staff who use equipment and administer procedures;

v. approves the nuclear services director's specification for the qualifications, training, functions, and responsibilities of the nuclear medicine staff;

w. approves the full-time, part-time, or consulting radiologist who is a doctor of medicine or osteopathy qualified by education and experience in radiology who supervises ionizing radiology services;

x. recommends to the Board the committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups.

y. makes statutory risk management Standard of Care determinations regarding Medical and Allied Health Staff events;

z. design data collection activities, review and analyze aggregate and individual performance data to measure and monitor clinical outcomes and the provision of patient care services;

aa. develop indicators for monitoring and evaluating the delivery of patient care services by specialty;

ab. identify areas of potential risks in the clinical aspects of patient care and

safety;

ac. evaluate new therapies and equipment for inclusion in the Hospital's scope of services and develop mechanisms for monitoring their appropriateness and utilization if adopted; and

ad. participate in concurrent and/or retrospective peer review and performance improvement activities to monitor individual practice patters or design process to address problems in the delivery of patient care services.

C. Meetings
The Medical Executive Committee shall meet at least ten (10) times per year, or more frequently as necessary, and shall report the activities, actions and recommendations of the Medical Staff to the Board. A permanent record of the proceedings, recommendations and actions of the Medical Executive Committee shall be maintained.

D. Removal of a Member of the Medical Executive Committee
The Medical Staff may initiate removal of a member of the Medical Executive Committee for cause, by a petition signed by at least ten (10) percent of the Members eligible to vote. Grounds for removal include but are not limited to the following:

1. failure to perform the duties of a Committee member;
2. failure to comply with/support/enforce the Medical Staff Documents and Hospital policies/procedures;
3. failure to comply with and/or support the compliance by the Hospital and the Medical Staff with applicable federal and state laws/regulations, and the standards of any regulatory or accrediting body with jurisdiction over the Hospital;
4. failure to maintain the qualifications for Membership on the Medical Executive Committee; or
5. failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or Medical Staff.

The process for removal of a member of the Medical Executive Committee shall occur in the manner described in Section 5.1(G) for the removal of an Officer of the Medical Staff. If the removal initiative is successful, the Board shall appoint a replacement to complete the remainder of the term of the vacated member.

6.3. CREDENTIALS COMMITTEE

A. Composition

1. The Credentials Committee shall be a Standing Committee. The Committee shall consist of at least seven (7) members of the Medical Staff and up to two (2) Advanced Practice Providers or Allied Health Professional members to assure multi-disciplinary representation of all Services. Each of the Chiefs of Service shall serve as members of the Committee with voting rights. The Advanced Practice Providers and Allied Health Professional member(s) may participate in an ex-officio capacity upon request of the Credentials Committee Chair or Medical Staff Chief of Staff. The

Chairperson shall serve a two (2) year term and must have previously served as a member of the Credentials Committee or held Medical Staff Office or the Chief of Service Position.

2. The Medical Executive Committee shall appoint the remaining Credentials Committee members, who shall serve two (2) year terms subject to reappointment without limitation. Committee members shall be eligible for reappointment for successive terms without limit. To the extent possible, and as determined by the Medical Executive Committee, the terms shall be staggered to promote continuity.
3. Hospital representatives, including the Chief Medical Officer, and the Administrative Manager of the Medical Staff Office, shall participate in Credentials Committee meetings in an ex-officio capacity, without voting rights.
4. The Credentials Committee shall function as a peer review committee consistent with federal and state laws. All Credentials Committee members shall adhere to Hospital confidentiality policies and keep in strict confidence all documents, reports, and information obtained by virtue of membership on the Committee.

B. Duties

The primary duties of the Credentials Committee shall include but not be limited to the following:

1. review the credentials of all applicants for Medical and Allied Health Staff appointment/reappointment and requests for or changes in Clinical Privileges, investigate such credentials and, as indicated, interview such applicants, and make a report to the Medical Executive Committee regarding its findings and recommendations;
2. make recommendations to the Medical Executive Committee concerning the establishment of written criteria for the granting of Clinical Privileges in each Service, based on input and recommendations of the Services;
3. make recommendations to the Medical Executive Committee and the Board regarding any revisions in the process for appointment; reappointment or the delineation of Clinical Privileges;
4. oversee a mechanism to ensure that all Medical Staff members and individuals holding Clinical Privileges maintain the necessary ongoing credentials as required by the Medical Staff Documents; and
5. oversee a mechanism to ensure that the scope of practice of individuals holding Clinical Privileges is limited to the Clinical Privileges granted.

C. Meetings

1. The Credentials Committee shall meet at least ten (10) times per year, or as often as necessary to conduct business, and shall maintain a permanent record of its activities. A report of the Committee's recommendations and activities shall be made to the Medical Executive Committee.

6.4. MEDICAL STAFF PEER REVIEW/RISK MANAGEMENT COMMITTEE

A. Composition

1. The Medical Staff Peer Review/Risk Management Committee shall be a Standing Committee of the Medical Staff. The Committee shall be chaired by the Vice Chief of Staff with additional voting members to include the Chiefs of Service, who shall serve for the extent of their terms in that capacity, and up to two (2) Advanced Practice Provider or Allied Health Professional members to assure multidisciplinary representation. The Chiefs of Service may serve successive terms without limit. Ex officio members without voting rights include the Chief Medical Officer, Chief Compliance Officer, Risk Management staff as appropriate and the Clinical Risk Manager. The Advanced Practice Provider and Allied Health Professional members may participate without a vote upon request of the Medial Staff Peer Review/Risk Management Committee Chair or Chief of Staff. Additional members, with or without a vote, may be appointed by the Chief of Staff as necessary to maintain a broad variety of specialists or to otherwise meet the needs of the committee.
2. Any member of the Medical Staff, any individual holding Clinical Privileges, or any employee of the Hospital may be invited to attend and participate in meetings of the Committee, as relevant and necessary to the duties and responsibilities of the Committee. Participants so invited shall be subject to the same confidentiality requirements and afforded the same protections as duly appointed members.
3. The Medical Staff Peer Review/Risk Management Committee shall function as a peer review committee consistent with federal and state laws. All Medical Staff Peer Review/Risk Management Committee members shall adhere to Hospital confidentiality policies and keep in strict confidence all documents, reports, and information obtained by virtue of membership on the Committee.

B. Duties

The primary duties of the Medical Staff Peer Review/Risk Management Committee include but are not limited to the following:

1. Review and analyze issues, identified as potential statutory Standard of Care deviations under the Kansas Risk Management statutes;
2. Recommend statutory risk management Standard of Care determinations regarding Medical and/or Allied Health Staff events to the Medical Executive Committee;
3. Report events with Outcome Classifications 1 and 2 in a summary format to the Medical Executive Committee for review and approval;
4. Refer events with Outcome Classifications 3 and 4 to the Medical Executive Committee for ratification and subsequent action;
5. Refer as appropriate any potential quality trends identified during the course of conducting business for further evaluation and follow up; and
6. Submit periodic activity reports to the Board.

C. Meetings
The Medical Executive Peer Review/Risk Management Committee shall meet at least ten (10) times per calendar year, or more often as necessary to fulfill its duties. A permanent record of the Committee's activities shall be maintained, with reporting to the Medical Executive Committee.

D. Confidentiality and Immunity

1. The Peer Review/Risk Management Committee is deemed to be a regularly constituted quality improvement committee pursuant to K.S.A. § 65-4915 and K.S.A. § 65-4921 et seq., as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a Regional Peer Review Committee are covered by the provisions of the Health Care Quality Improvement Act of 1986, K.S.A. § 65-4915 and K.S.A. § 65-4921 et seq. or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities.

6.5. OTHER MEDICAL STAFF COMMITTEES

The Medical Executive Committee may, by resolution, establish ad hoc Medical Staff committees from time to time to carry out the Medical Staff duties under these Bylaws, including without limitation, bylaws committees, nomination committees in accordance with Article 5, investigating committees in accordance with Article 7, and such other committees as set forth in the Medical Staff Organizational Manual or as the Medical Executive Committee deems appropriate to fulfill the Medical Staff's duties and responsibilities and the effective Medical Staff self-governance.

ARTICLE 7: ACTIONS ADDRESSING PRACTITIONER CONCERNS

7.1. AUTOMATIC RELINQUISHMENT AND TERMINATION

A. Automatic Relinquishments and Terminations for Loss of Qualifications.

1. Failure to Maintain Basic Qualifications: A Practitioner's Medical Staff Membership and Clinical Privileges will be Automatically Relinquished for up to ninety (90) days for failure to continuously maintain any of the Basic Qualifications for Medical Staff Membership or Clinical Privileges under Article 1 and Article 4, respectively, of these Bylaws, and as applicable to the Practitioner's Medical Staff category and specialty under Article 2 of these Bylaws, unless previously waived by the Board, including without limitation:

    a. Failure to continuously maintain an unrestricted professional license issued by the State of Kansas to practice in the Practitioner's specialty (e.g., medicine, dentistry, podiatry, nursing, etc.).

    b. Failure to continuously possess a current Federal Drug Enforcement

Agency (DEA) number if the requested Clinical Privileges contemplate prescribing controlled substances.

c. Failure to obtain or continuously maintain board certification as required for the Practitioner's Medical Staff Category, specialty and Privileges, unless excepted in accordance with the Medical Staff Documents.
    i. A Practitioner will be granted a sixty (60) day grace period before the Automatic Relinquishment for board certification becomes effective to provide evidence of current board certification, provided the Practitioner has completed or submitted all requirements for the board certification and is only awaiting confirmation of successfully attaining the board certification.
    ii. The Board has discretion to waive the board certification requirement, following receipt of a recommendation from the Medical Executive Committee in accordance with Section 1.4 above.

d. Arrest, indictment, conviction of, or entering a plea of guilty or no contest to, any felony.

e. Arrest, indictment, conviction of, or entering a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse, or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs.

f. Exclusion or suspension from participation in any federal health care program, including without limitation Medicare, Medicaid, and any other Federal Healthcare Program.

g. Failure to continuously maintain professional liability insurance coverage in the amount required by the Board.

h. Experience involuntary dismissal, termination, or suspension from any medical staff, or have Privileges involuntarily terminated, restricted, or suspended by any health facility for reasons of clinical competence or professional conduct.

i. Voluntary resignation or surrender of Medical Staff Membership or Clinical Privileges from any medical staff, or failure to renew Membership or Clinical Privileges while under investigation or to avoid investigation or other peer review activity by any health facility.

j. Failure to be a member, employee, or subcontractor of the group or person that holds an exclusive contract or closed service arrangement if the Practitioner's Privileges are in a service line operated under an exclusive or semi-exclusive contract or closed panel approved by the Board, unless exempted in accordance with Section 1.4 of these Bylaws. The Hospital may enforce such an Automatic Relinquishment even if the exclusive or semi-exclusive contract or other closed staff arrangement fails to specify this Automatic Relinquishment.

k. Failure to comply with any vaccination, screening, or personal protective

equipment requirements in accordance with policies adopted by the Hospital.

l. Failure to provide and continuously maintain a valid physical address, email address, and cell phone number that will be used as the primary methods of communication.

2. Failure to Maintain Privileges Qualifications: A Practitioner's Clinical Privileges will be Automatically Relinquished or limited for up to ninety (90) days for failure to continuously maintain the objective qualifications for the specific Clinical Privileges, unless previously waived by the Board, including without limitation:

    a. Failure to meet objective qualifications for Clinical Privileges under Article 4 of these Bylaws, including any required certifications (for example, subspecialty board certification, ATLS, ACLS).

        i. The Automatic Relinquishment under this Section 7.1 applies only to the specific Clinical Privileges for which the Practitioner fails to meet the objective qualifications.

        ii. A Practitioner will be granted a 60-day grace period before an Automatic Relinquishment for failure to maintain board certification becomes effective to allow the Practitioner to provide evidence of current required certification, provided the Practitioner has completed or submitted all requirements for the certification and is only awaiting confirmation of successfully attaining the certification.

B. Automatic Relinquishment and Termination Based on Specified Actions

1. A Practitioner's Medical Staff Membership and/or Clinical Privileges will be Automatically Relinquished or terminated as set forth in these Bylaws, including for any of the following:

    a. Failure to timely complete medical records in accordance with Section 1.5(A)(xiii), the Medical Staff Documents, and any Hospital policies or procedures on the completion and filing of medical records.

        i. If the Chief of Staff determines, in the Chief of Staff's sole discretion, that an urgent important patient care need exists, the Chief of Staff may defer enforcement of an automatic relinquishment related to a failure to complete medical records by extending the period of completion of a delinquent record for up to sixty (60) days.

        ii. If a Practitioner practices while subject to an Automatic Relinquishment for delinquent medical records, the Chief of Staff may refer the matter to the Medical Executive Committee for corrective action in accordance with Section 7.5.

        iii. This Automatic Relinquishment shall be in effect until all delinquent medical records are completed or until automatic termination as set forth in Subsection 7.1(E) below.

b. Material Misrepresentation discovered after the applicant is granted Medical Staff Membership or Clinical Privileges.

c. Failure to complete initial FPPE in accordance with Section 4.1(A) of these Bylaws and as set forth in the Medical Staff Focused Professional Practice Evaluation for Granting Privileges Policy.

d. Failure to notify, immediately (and in event later than five (5) business days after being provided notice of the change) the Chief of Staff or Medical Staff Office of a change, modification, or update as set forth in Section 1.5(B).

e. Refusal to participate in emergency room call coverage and other call panels approved by the MEC and the Board for which the Practitioner is responsible based on appointment, election, medical staff category, or otherwise.

f. Refusal to consent to immediate alcohol or drug testing when there is concern that the Practitioner may be impaired by current use of, or addiction to, alcohol or drugs in accordance with Section 1.5(C).

g. Refusal to consent to health examination or screening when there is concern that the Practitioner cannot exercise Clinical Privileges in a safe and competent manner in accordance with Section 1.5(C), and the Hospital's policies related to Practitioner health and wellbeing.

2. Failure of a Practitioner to timely submit a completed application for reappointment in accordance with Article 3 of these Bylaws will result in the automatic expiration of the Practitioner's Medical Staff Membership and Clinical Privileges on the date the Practitioner's then-current appointment and Privileges expire.

C. Procedural Rights

1. A Practitioner who is subject to Automatic Relinquishment, automatic termination, or automatic expiration of their Medical Staff Membership and/or Clinical Privileges under this Section 7.1 is not entitled to any procedural rights, including any hearing or appeal under Article 8 of these Bylaws or the Medical Staff Documents.

2. The Automatic Relinquishment, termination, or expiration of Medical Staff Membership and/or Clinical Privileges does not prohibit a Practitioner from submitting an application for initial appointment or for new Medical Staff Membership or Clinical Privileges, which will be reviewed in accordance with Section 3.2 of these Bylaws and the Medical Staff Documents.

3. If a Practitioner experiences one or more Automatic Relinquishment in accordance with the Bylaws, the Medical Staff Documents, or the policies and procedures of the Hospital or the Medical Staff, the matter may be referred to the appropriate Medical Staff officer or committee for Peer Review at any time. Peer Review may include, without limitation, collegial intervention, letters of warning, professional practice evaluation, or Formal Investigation, and may be reviewed in conjunction with the consideration of any reappointment application or request for renewal or increase of Clinical Privileges in accordance with these Bylaws and the Medical Staff Documents.

D. Automatic Reinstatement:

1. A Practitioner who is subject to Automatic Relinquishment under this Section 7.1 will be automatically reinstated to Medical Staff Membership and Clinical Privileges, as applicable, if, prior to expiration of the ninety (90) day period, the Practitioner furnishes documented proof of compliance with the basic qualification for Medical Staff Membership or the objective qualification for Clinical Privileges that formed the basis for the Automatic Relinquishment. The Practitioner must submit the documented proof to Medical Staff Office.

E. Automatic Termination:

1. If a Practitioner remains subject to an Automatic Relinquishment under this Section 7.1 for more than ninety (90) days, the Practitioner's Medical Staff Membership and Clinical Privileges, as applicable, (or the affected Clinical Privileges, if the suspension is a partial suspension) shall be automatically terminated.

F. Exclusive Contracts:

1. A Practitioner who was granted Clinical Privileges in a service line operated under an exclusive or semi-exclusive contract or a closed service approved by the Board will not have their Clinical Privileges Automatically Relinquished under Section 7.1 above if the Hospital enters into an exclusive or semi-exclusive contract or closed service arrangement with a new group or person, and on or before the effective date of the new exclusive or semi-exclusive contract or closed service arrangement, the Practitioner becomes a member, employee, or subcontractor of the group or person that holds the exclusive or semi-exclusive contract or is the subject of the closed service approved by the Board.

G. Notifications And Patient Continuity

1. A Practitioner subject to Automatic Relinquishment or termination shall be notified of such Automatic Relinquishment or termination by Special Notice. The Practitioner's actual receipt of the Special Notice is not required for the Automatic Relinquishment or termination to become effective.
2. A Practitioner subject to automatic expiration shall be notified of such automatic expiration. The Practitioner's actual receipt of the Notice is not required for the automatic expiration to become effective.
3. Notice of an Automatic Relinquishment, termination, or expiration shall also be given to the Medical Executive Committee and the Board, but such Notice is not required for the suspension, termination, or expiration to become effective.
4. Patients affected by an Automatic Relinquishment, termination, or expiration of a Practitioner's Medical Staff Membership and/or Clinical Privileges shall be assigned to another Practitioner by the Chief of Staff considering, where feasible, the wishes of the patient and the affected Practitioner in the choice of a substitute Practitioner.

7.2. SUMMARY SUSPENSION

A. Criteria for Initiation

1. The Chief of Staff, Vice Chief of Staff, a Chief of Service, the Chief Medical Officer, or

the Chief Executive Officer shall each have the authority to summarily suspend or restrict the Medical Staff Membership or all or any portion of the Clinical Privileges of a Practitioner whenever the failure to take such action may result in imminent danger to the health or safety of any individual. If a summary suspension or restriction is imposed by the Chief Executive Officer or the Chief Medical Officer prompt notice of the summary suspension or restriction will be provided to the Chief of Staff or Vice Chief of Staff.

2. When consistent with safety, the person authorized to impose a summary suspension or restriction may make reasonable efforts to interview the Practitioner before or at the time the summary suspension or restriction is being imposed. Such person shall document the interview in the Practitioner's quality file. The interview shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney participate in the interview.
3. Unless otherwise indicated by the terms of the summary suspension or restriction, such summary suspension or restriction shall become effective immediately upon imposition.
4. Unless otherwise indicated by the terms of the summary suspension or restriction, the Practitioner's patients at the Hospital shall be promptly assigned to another Member by the Chief of Staff or Chief of Service, with assistance of the Chief Medical Officer and considering, where feasible, the wishes of the patient and the affected Practitioner in the choice of a substitute Member.
5. Written Notice of the summary suspension or restriction will be promptly given to the affected Practitioner and the Medical Executive Committee no later than within three (3) days after imposition of the summary suspension. The written Notice shall constitute a request to the Medical Executive Committee for a formal corrective action Investigation.
6. The Chief of Staff may authorize an expedited initial review of the matter on behalf of the Medical Executive Committee, to be conducted by a standing or ad hoc Medical Staff committee.
7. As part of the expedited initial review, the standing or ad hoc Medical Staff Committee may interview the affected Practitioner. The interview shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney participate in the interview.
8. The Chief of Staff has the authority to lift the summary suspension or restriction before conclusion of the expedited initial review or Medical Executive Committee action under Section 7.5(C) below, if lifting the summary suspension or restriction is deemed appropriate. If the Chief of Staff lifts the summary suspension or restriction, the Chief of Staff must provide prompt notice to the Medical Executive Committee with a summary of the rationale for concluding that there is no longer imminent danger to the health or safety of any individual.

B. Medical Executive Committee Action

1. The standing or ad hoc Medical Staff committee will report to the Medical Executive

Committee on the preliminary results of the expedited initial review, if any, as soon as practical, but within fourteen (14) days of imposition of the summary suspension or at the time of the Medical Executive Committee meeting, whichever is earlier.

2. The Medical Executive Committee may terminate an expedited initial review authorized by the Chief of Staff, may initiate a formal Investigation to be conducted by an Investigating Body in accordance with Section 7.5 below, or may conclude that there has been a sufficient review of the facts to make a determination without a Formal Investigation.
3. The Medical Executive Committee may, at its sole discretion, require the affected Practitioner to meet with the Medical Executive Committee. If not required to meet by the Medical Executive Committee, the affected Practitioner may request an interview with the Medical Executive Committee. The interview shall be convened as soon as reasonably possible under all circumstances. The interview shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney participate in the interview. If the affected Practitioner does not request an interview, the Medical Executive Committee may request an interview with the affected Practitioner. A summary of the interview shall be documented in the Practitioner's confidential file.
4. As soon as practicable after imposition of the summary suspension or restriction, but no later than fourteen (14) days after imposition of the summary suspension, the Medical Executive Committee shall be convened to review the matter that resulted in the summary suspension or restriction, review the preliminary results of the expedited initial review, and consider the action taken.
5. After considering the matter resulting in the summary suspension or restriction, the expedited initial review, if any, and the Practitioner's interview, if any, the Medical Executive Committee shall determine whether to continue, modify, or terminate the summary suspension or restriction, or make other recommendations, including initiating a Formal Investigation in accordance with Section 7.5 below.
6. The Medical Executive Committee will also determine whether there is sufficient information to make a final recommendation on the matter, or whether to initiate or continue a Formal Investigation in accordance with Section 7.5 below. If the Medical Executive Committee continues the summary suspension or restriction, and initiates or continues a formal corrective action Investigation, the standing or ad hoc Medical Staff committee conducting the expedited initial review, if any, shall make reasonable efforts to forward a written report of the Investigation to the Medical Executive Committee as soon as practicable.
7. At any time during the summary suspension or restriction, the Medical Executive Committee may recommend or take any other action in accordance with these Bylaws.
8. If the Medical Executive Committee's action or recommendation is not an Adverse Action for the Practitioner, the Medical Executive Committee's action or recommendation will be forwarded to the Board for final action, and the Practitioner will not be entitled to the hearing and appeal procedures under Article 8.

9. If a recommendation by the Medical Executive Committee is an Adverse Action that would entitle the Practitioner to a hearing and appeal in accordance with Article 8 of these Bylaws, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer. The Chief Executive Officer will promptly notify the Practitioner by Special Notice of the decision and the reasons for the recommendation and inform the Practitioner of their right to a hearing and appeal under Article 8 of these Bylaws.
10. Unless it expires by its terms or is earlier terminated by the Medical Executive Committee, the summary suspension or restriction shall continue during the pendency and completion of the Formal Investigation process and the completion or waiver of any hearing and appellate procedures as set forth in these Bylaws.

C. Notice of Summary Suspension or Restriction and Hearing Rights
    1. A summary suspension or restriction that is for longer than thirty (30) days shall constitute an Adverse Action, which entitles the Practitioner to to a hearing and appeal in accordance with Article 8 of these Bylaws, provided, however, the hearing for the summary suspension or restriction shall be consolidated with the hearing for any other Adverse Action.
    2. If the summary suspension or restriction lasts longer than thirty (30) days or the Medical Executive Committee recommends any Adverse Action in addition to the summary suspension or restriction that entitles the Practitioner to a hearing and appeal in accordance with Article 8 of these Bylaws, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer. The Chief Executive Officer will promptly notify the Practitioner by Special Notice and provide written Notice to the Board and Chief Executive Officer of the decision and the reasons for the recommendation and inform the Practitioner of their right to a hearing and appeal under Article 8 of these Bylaws.

7.3. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

A. When questions or concerns arise relating to a Practitioner's qualifications, competence, professional conduct, or quality and appropriateness of care, a Medical Staff Officer, Department Chair, Chief of Service (each a "Medical Staff Leader"), or the Chief Medical Officer or a Chief of Service in collaboration with a Medical Staff Leader may initiate informal, collegial Peer Review. This process is optional and not required.

B. Concerns related to a Practitioner's physical, mental, or emotional health or wellbeing including without limitation mental or emotional distress, the influence of alcohol or other mood altering medications, deterioration through the aging process, disease process, or loss of motor skill, chemical or alcohol dependency, substance use disorder, psychiatric dysfunction, any detrimental effects of aging, injury or condition, or any other medical condition which presents or may present a potential risk to patients or Hospital staff who work with or see patients or has the potential of reducing the ability of the Member to care for patients safely or effectively interact with Hospital staff will be addressed in accordance with the Hospital's policies on Practitioner health and wellness.

C. Collegial intervention is intended to be implemented on a voluntary and collegial basis within the Medical Staff. If necessary, changes cannot be implemented on a voluntary basis a matter may be referred for corrective action in accordance with this Article, which process may trigger mandatory reporting requirements depending on the type of action implemented.

1. The goal of collegial intervention is to arrive at voluntary, responsive actions by the Practitioner to resolve the issue that has been raised. Collegial efforts and voluntary progressive steps may be carried out within the discretion of the Medical Staff. Use of these efforts are not mandatory.
2. Collegial intervention efforts and voluntary progressive steps are part of the Medical Staff's Peer Review, and may include, but are not limited to, the following:
    a. Informal discussions or formal meetings with the affected individual;
    b. Sharing and discussing applicable policies, such as policies regarding appropriate professional conduct, emergency call obligations, and the timely and adequate completion of medical records;
    c. Counseling, mentoring, monitoring, observational proctoring, consultation, and education, including formal retraining programs;
    d. Sharing the results of OPPE and FPPE, comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform the Practitioner's practice to appropriate norms;
    e. Communicating expectations for professionalism and behaviors that promote a culture of safety;
    f. Informational letters of guidance, education, counseling; and
    g. Performance improvement plans that do not restrict or limit the Practitioner's Clinical Privileges.

D. The applicable Medical Staff Leader or Chief Medical Officer will determine whether document collegial intervention efforts and the outcome in writing and place it in the Practitioner's file. Documentation of the collegial intervention efforts is strongly encouraged, but not required in all instances. The Practitioner may, but is not required to, submit a written response to the collegial intervention, which will be placed in the Practitioner's file.

E. If collegial intervention efforts do not resolve the concern, the Medical Staff may proceed with further Peer Review as set forth in these Bylaws.

F. Collegial intervention shall not constitute a Formal Investigation, restriction of Clinical Privileges, or grounds for any formal hearing or appeal rights under these Bylaws.

G. The informal collegial intervention process described in this Section is in addition to the other Peer Review processes set forth in these Bylaws.

7.4. INITIAL INQUIRY

A. Any concerns relating to a Practitioner's qualifications, competence, judgment, clinical practice, or professional conduct, may be referred to a Medical Staff Officer, Department Chair, Chief of Service, the chair of any standing committee, the Chief Medical Officer, or the Chief

Executive Officer, regarding any of the following:

1. The clinical competence or clinical practice of a Practitioner including patient care, treatment or management, and failure to follow the appropriate standards of care and/or protocols and guidelines adopted by the Medical Staff;
2. The known or suspected violation by a Practitioner of applicable internal and external ethical standards, the adopted standards of the Medical Staff as set forth in the Medical Staff Documents, or any applicable laws or regulations;
3. Professional conduct that is considered lower than or inconsistent with applicable standards of the Hospital, detrimental to patient safety or the delivery of quality patient care within the Hospital, or is considered to be disruptive to the operations of the Hospital or its Medical Staff such that the quality or efficiency of patient care is or may be affected;
4. The ability of the Practitioner to perform, with or without reasonable accommodation, the essential functions of Medical Staff Membership and/or the granted Clinical Privileges; or
5. The Practitioner's failure to satisfy the General Qualifications for Medical Staff Membership or the granted Clinical Privileges as set forth in Section 3.1.

B. The person or committee to whom the concern is referred will make a sufficient initial inquiry to determine whether the concern is credible and, if so, whether further review or action is appropriate, which may include any of the following:
    1. Collegial intervention in accordance with Section 7.3;
    2. Referral to an appropriate Peer Review committee;
    3. Referral to the Medical Executive Committee;
    4. Consideration of Summary Suspension or restriction; or
    5. Manage the matter in accordance with a relevant Medical Staff or Hospital policy.

C. No inquiry or other action taken pursuant to this Section 7.4 will constitute an Investigation as defined in these Bylaws. Notwithstanding the forgoing to the extent required by applicable law resignation by the Practitioner of their Medical Staff Membership and/or Clinical Privileges during this initial inquiry may result in a National Practitioner Data Bank report as a surrender of Privileges while under Investigation.

7.5. INVESTIGATIONS

A. Criteria for Initiation
    1. A request for an Investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request for an Investigation itself, it shall make an appropriate record of the reasons. An Investigation may be initiated in response to the circumstances in a single case or a pattern or trend in performance.
    2. Any person may provide information to the Medical Executive Committee about the conduct, performance, or competence of its Members and Practitioners with Clinical Privileges within or outside the Hospital.

3. The Medical Executive Committee will review the matter in question, may discuss the matter with the Practitioner, and will determine whether to approve an Investigation or direct that the matter be handled pursuant to another process. The review and discussion with the Practitioner shall not constitute a “hearing” as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney present at the discussion with the Medical Executive Committee.
4. When reliable information indicates a Practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care; (2) unethical; (3) illegal; (4) contrary to the Medical Staff Documents; or (5) below applicable professional standards, a request for an Investigation concerning such Practitioner may be initiated.
5. Initiation by Board
    a. If the Medical Executive Committee fails to initiate an Investigation or take corrective action based on reliable information, the Board may direct the Medical Executive Committee to initiate an Investigation after consultation with the Medical Executive Committee.
    b. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request.
    c. If the Medical Executive Committee fails to take action in response to the Board's direction, the Board may initiate an Investigation or corrective action itself after written notice to the Medical Executive Committee. Such Investigation or corrective action by the Board must comply with these Medical Staff Bylaws.
6. Once a vote has been taken to initiate an Investigation, the Medical Executive Committee will promptly provide the Practitioner with Notice that an Investigation has begun documenting the date and time of commencement of the Investigation. In rare instances, Notice to the Practitioner may be delayed if, in the judgment of the Medical Executive Committee, informing the Practitioner might compromise the integrity of the Investigation or disrupt the operation of the Hospital or Medical Staff.

B. Investigation
1. The Medical Executive Committee may conduct the Investigation itself as the Investigating Body or may delegate the Investigation to a subcommittee of the MEC, a standing or ad hoc committee of the Medical Staff, or an individual or outside consultant or consulting entity to serve as the Investigating Body.
2. The Investigating Body may include individuals who are not Members of the Medical Staff and have not been granted Clinical Privileges at the Hospital. The Investigating Body may not include any individual who:
    a. Is in direct economic competition with the Practitioner being investigated;
    b. Is professionally associated with, a relative of, or involved in an ongoing referral relationship with, the Practitioner being investigated; or
    c. Has an actual bias, prejudice, or conflict of interest that would prevent the

individual from fairly and impartially considering the matter;

3. The Investigating Body may:
    a. Review relevant documents, which may include patient records, incident reports, and relevant literature or guidelines;
    b. Conduct interviews;
    c. Use outside consultants, as needed; or
    d. Require an examination or assessment by a health care professional(s) acceptable to the Investigating Body. The Practitioner being investigated will execute a release allowing the Investigating Body to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results of the examination or assessment to the Investigating Body. Failure to obtain the requested evaluation or to execute the appropriate releases and authorizations, and to do so within the required time frame, will, upon Notice to the individual, result in the Automatic Relinquishment of Membership and Clinical Privileges as set forth in these Bylaws.
4. As part of the Investigation the Practitioner shall be given an opportunity to provide information in a manner and upon such terms as the Investigating Body deems appropriate, and may, upon the Investigating Body's discretion, be invited to meet with the Investigating Body. Prior to meeting with the Investigating Body, the Practitioner will be informed of the concerns being investigated. Such meeting shall not constitute a "hearing" as that term is used in these Bylaws, and the Practitioner is not entitled to have an attorney present at the meeting, nor shall the procedural rules with respect to hearings or appeals apply.
5. If the Investigation is delegated to an Investigating Body other than the Medical Executive Committee, such Investigating Body shall proceed with the Investigation in a prompt manner and shall forward a written report of the Investigation to the Medical Executive Committee as soon as practicable.
    a. The Investigating Body will make a reasonable effort to complete the Investigation and issue its report within thirty (30) Days, provided that an outside review is not necessary. When an outside review is used, the Investigating Body will make a reasonable effort to complete the Investigation and issue its report within thirty (30) Days of receiving the results of the outside review. These time periods are guidelines and are not directives that create any right for a Practitioner to have an Investigation completed within such time periods.
    b. The written report shall include the Investigating Body's findings and may include recommendations for appropriate actions.
6. Despite the status of any Investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the Investigation, or other action deemed appropriate by the Medical Executive Committee.

C. Medical Executive Committee Action

1. As soon as practicable after the conclusion of the Investigation, the Medical Executive Committee shall consider the Investigating Body's report and recommendations, and may request any additional information to assist in its deliberations, request an interview with the Practitioner, and/or request that the Practitioner undergo a physical or mental health examination or assessment in accordance with Section 1.5(C) of these Bylaws.
2. The Medical Executive Committee may take any action or make any recommendation deemed appropriate, including without limitation any of the following:
    a. Determine no disciplinary action be taken;
    b. Defer action for a reasonable time where circumstances warrant;
    c. Issue letters of admonition, censure, reprimand, or warning. In the event such letters are issued by the Medical Executive Committee, the affected Practitioner may make a written response, which may be placed in the Practitioner's Peer Review file;
    d. Recommend the imposition of terms of probation or special limitation upon continued Medical Staff Membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;
    e. Recommend reduction, modification, suspension or revocation of some or all Clinical Privileges;
    f. Recommend reductions of Medical Staff Membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care;
    g. Recommend suspension, revocation, or probation of Medical Staff Membership;
    h. Take other actions deemed appropriate under the circumstances.
3. The Medical Executive Committee will make a reasonable effort to complete the Investigation and issue its report within ninety (90) Days of the initiation of the Investigation. These time periods are guidelines and are not directives that create any right for a Practitioner to have an Investigation completed within such time periods.

D. Subsequent Action

1. The recommendation of the Medical Executive Committee will take effect immediately, unless the recommendation is an Adverse Action that entitles the Practitioner to a prior hearing and appeal in accordance with Article 8 of these Bylaws.
2. Actions or Recommendations that constitute an Adverse Action as defined in these Bylaws:
    a. If a recommendation by the Medical Executive Committee is an Adverse

Action that would entitle the Practitioner to a hearing and appeal in accordance with Article 8 of these Bylaws the Board shall be generally informed of but shall not receive detailed information and shall not take action on, the recommendation until the Practitioner has exhausted or waived the Practitioner's procedural rights under these Bylaws.

b. The Medical Executive Committee will forward its recommendation to the Chief Executive Officer. The Chief Executive Officer will promptly notify the Practitioner by Special Notice of the decision and the reasons for the recommendation and inform the Practitioner of their right to a hearing and appeal under Article 8 of these Bylaws.

3. Actions or Recommendations that are not Adverse Actions as defined in these Bylaws:

    a. If a recommendation by the Medical Executive Committee is not an Adverse Action that would entitle the Practitioner to a hearing and appeal the recommendation or action shall be promptly transmitted to the Board.

    b. As soon as practicable after the Board will review the report and recommendations from the Medical Executive Committee. Based upon the report, the Board may accept, modify, or reject any recommendation from the Medical Executive Committee.

    c. If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the Practitioner to a hearing and appeal in accordance with Article 8 of these Bylaws, following a recommendation from the Medical Executive Committee that did not entitle the Practitioner to a hearing and appeal, the Chief Executive Officer, Board Chair, or designee shall promptly notify the Practitioner by Special Notice of the decision and the reasons for the recommendation, and inform the Practitioner of their right to a hearing and appeal under Article 8 of these Bylaws.

4. No final Adverse Action will occur until the Practitioner has exhausted or waived the Practitioner's procedural rights under these Bylaws.

7.6. CIRCUMSTANCES THAT MAY REQUIRE EXTERNAL PEER REVIEW:

A. External Peer Review will take place under the following circumstances if and only if deemed appropriate based on a recommendation from a Peer Review body (including the Medical Executive Committee, Board, or an Investigating Body). No Practitioner can require the Hospital to obtain external Peer Review if it is not deemed appropriate by the applicable Peer Review body. Circumstances, which may require external Peer Review include:

    1. Lack of internal expertise: when no one on the Medical Staff has adequate expertise in the specialty under review; or when the only Practitioners on the Medical Staff with that expertise are partners, associates, or direct competitors of the Practitioner under review. External Peer Review will take place if this potential for conflict of

interest cannot be appropriately resolved by the Medical Executive Committee or Board.

2. Litigation: when dealing with the potential for a lawsuit.
3. Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff committees and conclusions from this review will directly impact a Practitioner's Membership or Privileges.
4. New technology or Privileges: when the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
5. Miscellaneous issues: when the Medical Staff needs an external expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring.
6. Other circumstances deemed appropriate by the Medical Executive Committee or the Board.

7.7. LEAVE OF ABSENCE

A. Grounds
A leave of absence may be granted to any Member by the Board in accordance with the Credentialing Policy and the Medical Staff policies on leave of absence. All Members who, for any reason, will not exercise their Clinical Privileges for a period of more than ninety (90) days must request a leave of absence in accordance with the Medical Staff policies on leave of absence.

B. Period
Any such leave of absence shall be granted for a specified period not to exceed one (1) year except for military service. During the period of time of the leave, the Member's Clinical Privileges, prerogatives and responsibilities shall be suspended.

C. Effect on Membership
A Member's leave of absence shall not suspend or defer the Member's current appointment to the Medical Staff, and shall not relieve a Member of their obligation to reapply for appointment pursuant to the Credentialing Policy of the Medical Staff.

D. Reinstatement
Members wishing to be reinstated following a leave of absence granted in accordance with Section 7.7(A) above must apply for reinstatement in accordance with the Medical Staff policies on leave of absence.

7.8. VOLUNTARY RESIGNATION

A. Resignations from the Medical Staff and/or relinquishment of Clinical Privileges shall be submitted in writing to the relevant Clinical Service Chief for transmittal to the Executive Committee and will be effective on the date stated in the writing with no formal action required. The Chief of Staff will acknowledge receipt of the resignation, in writing, and the member will be promptly notified of any medical records containing documentation deficiencies.

B. When a member's resignation is accepted or Clinical Privileges are relinquished during the course of an investigation related to potential corrective action in accordance with Article 7 related to issues of clinical competency or professional conduct, a report will be submitted to the National Practitioner Data Bank, as required by law.

ARTICLE 8: FAIR HEARINGS AND APPEALS

8.1. RIGHT TO FAIR HEARING

A. **Grounds for a Hearing**
Except as otherwise specifically provided in the Medical Staff Documents, a Practitioner may request a Hearing when an Adverse Action is taken or recommended against the Practitioner, including those Adverse Actions based on findings made after an Investigation indicating that the affected person lacks qualifications, has provided substandard or inappropriate care, or has exhibited inappropriate professional conduct. APPs and AHPs are not entitled to the procedural rights, including hearings and appeals, provided in this Article 8. Adverse Actions may be recommended or taken by the Medical Executive Committee or the Board, and summary suspension or restrictions as an Adverse Action may be taken by the persons and committees set forth in Section 7.2 (Summary Suspensions) of these Bylaws.

B. **Recommendations or Actions Not Grounds for a Hearing**
Recommendations or actions that do not constitute grounds for a Hearing, and shall take effect without hearing or appeal, include but are not limited to:

1. an oral or written admonition, reprimand or warning;
2. imposition of supervision, observation or general consulting requirements on a Medical Staff appointee or applicant for Clinical Privileges which requirements do not restrict the Clinical Privileges of the affected individual or the delivery of professional services to patients;
3. imposition or extension of a probationary period with special monitoring conditions;
4. denial of Medical Staff appointment, reappointment and/or Clinical Privileges or reduction in Medical Staff category because the applicant or Member fails to meet minimum threshold requirements for such appointment, reappointment, privileges and/or category;
5. ineligibility for Medical Staff appointment, reappointment and/or Clinical Privileges in whole or in part because a Service has closed or there exists an exclusive contract between the Hospital and other Member(s) for the provision of services within the scope of the requested privileges;
6. termination or revocation of Medical Staff appointment, reappointment and/or Clinical Privileges in whole or in part because a Service has closed or there exists an exclusive contract between the Hospital and other Member(s) for the provision of services within the scope of the granted privileges;
7. termination of an employment or professional services contract unless such contract provides otherwise;
8. ineligibility for Medical Staff appointment, reappointment and/or Clinical Privileges because of lack of facilities, equipment or because the Hospital has elected not to

perform or does not provide the professional services the applicant seeks to provide or the procedure(s) for which Clinical Privileges are sought;

9. revocation, suspension or restriction of Medical Staff appointment, reappointment and/or Clinical Privileges for reasons not based on professional competency or conduct as determined by the Medical Executive Committee or Board, as applicable;
10. revocation, suspension or restriction of Medical Staff appointment, reappointment and/or Clinical Privileges as provided in Section 7.1 regarding automatic relinquishment;
11. denial, revocation, suspension or restriction of temporary privileges;
12. the imposition of requirements of retraining, additional training, continuing education, and/or corrective counseling;
13. suspension of privileges, either in whole or in part, and/or Medical Staff Membership for less than thirty (30) days and during which an investigation is being conducted to determine the need for further action;
14. the imposition of an investigation into any matter reasonably related to Medical Staff Membership or the performance of Clinical Privileges;
15. the rejection of or refusal to accept an application for initial appointment, reappointment and/or Clinical Privileges (i) where the application is incomplete; (ii) where the application reasonably reflects that the applicant fails to meet the minimum threshold requirements for such appointment, reappointment and/or Clinical Privileges; or (iii) where the applicant is requesting Clinical Privileges in a Service in which the number of medical staff appointees has been limited in accordance with Medical Staff and/or Board Bylaws;
16. the denial of a request for a waiver or reduction of the required minimum liability insurance coverage as specified in the Medical Staff Documents;
17. removal from the call roster or on-call schedule;
18. any voluntary relinquishment or voluntary limitation of Medical Staff appointment, reappointment and/or Clinical Privileges;
19. mandatory reports made to state professional licensing entities pursuant to the Kansas Risk Management statutes or to other entities as required by federal or state law/regulation; or
20. any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Member, or which is not based upon a subjective determination of the professional competency or conduct of the Practitioner.

8.2. NOTICE OF ADVERSE ACTION OR RECOMMENDATION

A Practitioner against whom an Adverse Action or recommendation has been taken pursuant to the Medical Staff Documents shall promptly be given Special Notice of such Adverse Action or recommendation. Such notice shall:

A. state the reasons for the Adverse Action or recommendation and provide a concise statement of the affected Practitioner's alleged acts or omissions and a list of the specific or representative patient medical records, as appropriate;

B. advise the Practitioner of their right to a Hearing pursuant to the provisions of the Medical Staff Bylaws, the Credentialing Policy and this Fair Hearing Plan;

C. advise the Practitioner that they have thirty (30) days following receipt of the notice to submit a written request for a hearing;

D. state that failure to request a hearing in the manner set out in this Plan and within the proscribed time period shall constitute a waiver of any right to a Hearing and an appellate review of the matter, and that in the case of such waiver, the recommended adverse action shall become final upon approval by the Board;

E. provide a summary of the Practitioner's rights at the Hearing; and

F. state that upon receipt of their Hearing request, the Practitioner shall be notified of the date, time and place of the Hearing.

8.3. REQUEST FOR HEARING

The Practitioner entitled to a Hearing shall have thirty (30) days following their receipt of the Special Notice pursuant to Section 8.2 of this Article to file a written request for a Hearing. Such request shall be in writing addressed to the Chief of Staff. The request shall include the name, address, and telephone number of any attorney or other representative retained by the Practitioner as of the date of the Practitioner's request for a hearing. In the event the Practitioner has not engaged an attorney or other representative by the date of the Practitioner's request for a hearing, the Practitioner may identify the Practitioner's attorney or other representative in accordance with Section 8.8.

8.4. FAILURE TO REQUEST HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 8.3 of this Article waives any right to such Hearing and to any appellate review to which they might otherwise have been entitled with one of the following results:

A. in the case of an adverse recommendation by the Medical Executive Committee, such waiver shall constitute acceptance of that recommendation by the Practitioner, which shall become effective pending final approval of the Board; or

B. in the case of an adverse action by the Board, such waiver shall constitute acceptance of the action, which shall become immediately effective as the final decision of the Board.

8.5. PROCEDURE UPON RECEIPT OF A REQUEST FOR HEARING

Upon receipt of a timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff or to the Board, depending on whose recommendation or action prompted the request for hearing. The Practitioner shall be sent a Special Notice, stating the following:

A. the place, time, and date, of the Hearing, which date shall not be less than 30 days after the date of the notice of the Hearing, unless both parties agree otherwise;

B. a list of witnesses (if any) expected to testify at the Hearing on behalf of the body whose action gave rise to the Hearing request; and

C. that the Practitioner has the following rights related to the Hearing:

    1. to be present at the hearing;
    2. to be represented by an attorney or other person of the Practitioner's choice;
    3. notice of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;
    4. to have a record made of the proceedings, a copy of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;
    5. to call, examine, and cross-examine available witnesses;
    6. to present evidence determined to be relevant by the Hearing Officer or Chair of the Hearing Panel, regardless of its admissibility in a court of law;
    7. to submit a written statement at the close of the Hearing;
    8. upon completion of the Hearing, the right to receive a copy of the written recommendation of the Hearing Panel, including a statement of the basis for the recommendation; and
    9. upon completion of the Hearing and/or Appellate Review, as appropriate, the right to receive a copy of the final decision of the Board, including a statement of the basis for the decision.

8.6. PRE-HEARING CONFERENCE

A. Prior to the hearing, the chair of the Hearing Panel or the Hearing Officer shall conduct a pre-hearing conference. At such conference the Practitioner, by personal appearance of through their counsel or representative, if any, and a representative of the Medical Executive Committee or the Board, or its counsel, if any, shall attend to discuss stipulations of fact, amendment to the grounds for action or the issues at dispute, and changes in the witness lists. Additionally, those in attendance may discuss the procedure for the conduct of the hearing and/or the possibility of resolution by consent. The Hearing Panel or the Hearing Officer may require the Practitioner and the Medical Executive Committee or the Board to submit an outline setting forth, so far as the parties reasonably know:

    1. The issues to be raised at the hearing;
    2. Witnesses to call at the hearing and the subject matter upon which such witnesses will testify;
    3. A description of written or documentary evidence the parties intend to introduce as evidence at the hearing; and
    4. A short summary of matters the parties will demonstrate at the hearing.

8.7. APPOINTMENT OF HEARING PANEL

A. **Adverse Action Recommendation By The Medical Executive Committee**
A Hearing occasioned by an adverse recommendation of the Medical Executive Committee shall be conducted by an Ad Hoc Hearing Panel appointed by the Chief Executive Officer and the Chief of Staff and composed of three (3) Members of the Medical Staff. In the rare circumstance the Hearing Panel cannot be appointed from the Medical Staff, a physician(s) not on staff at the Hospital may be appointed. One of the Hearing Panel members shall be appointed Chair, who shall preside over the Hearing. The Hearing Panel members shall gain no direct financial benefit from the outcome of the controversy, shall not be in direct economic competition with the Practitioner, shall not be a member of the current Medical Executive Committee or the Board of Directors, shall not have acted as accusers, investigators, fact finders or initial decision-makers in the matter at any stage of the process, and shall not have actively participated in the consideration of the matter leading up to the recommendation. However, knowledge of the matter shall not preclude an individual otherwise qualified from serving as a member of the Hearing Panel.

B. **Adverse Action By The Board**
A Hearing occasioned by an adverse action of the Board of Directors shall be conducted by an Ad Hoc Hearing Panel appointed by the Chief Executive Officer and the Chair of the Board and composed of three (3) Members of the Medical Staff. In the rare circumstance the Hearing Panel cannot be appointed from the Medical Staff, a physician(s) not on staff at the Hospital may be appointed. One of the Hearing Panel members shall be appointed Chair, who shall preside over the Hearing. The Hearing Panel members shall gain no direct financial benefit from the outcome of the controversy, shall not be in direct economic competition with the Practitioner, shall not be a member of the current Medical Executive Committee or the Board of Directors, shall not have acted as accusers, investigators, fact finders or initial decision-makers in the matter at any stage of the process, and shall not have actively participated in the consideration of the matter leading up to the action. However, knowledge of the matter shall not preclude an individual otherwise qualified from serving as a member of the Hearing Panel.

C. **Challenges for Cause**
When the Practitioner has been notified of the appointed Panel members, the Practitioner may challenge the appointment of Hearing Panel members for any cause that would indicate bias or predisposition. The Chair or, if the Chair is challenged the Chief of Staff, shall determine the validity of such challenge, which decision shall be final. The Practitioner shall have five calendar days from the date of notice of the Panel members to submit written objections to the appointment of any proposed Panel member, clearly stating the basis for such objection(s). Failure to make objections in this manner or in accordance with this time frame shall be considered a voluntary waiver of the opportunity to object.

8.8. HEARING PROCEDURE

A. **Personal Presence**
The personal presence of the Practitioner who requested the hearing shall be required at the Hearing. If the Practitioner fails without good cause, as determined by the Hearing Panel, to appear and proceed at such Hearing, the Practitioner shall be deemed to have waived their rights in the same manner and with the same consequence as provided in Section 8.4 of this

Article.

B. **Presiding Officer**
The Chair of the Hearing Panel shall be the Presiding Officer. 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.

C. **Appointment of A Hearing Officer or Legal Consultant**
The use of a Hearing Officer to preside at the Hearing is optional and shall be determined and appointed by the Chief of Staff. The Hearing Officer need not be an attorney but must be experienced in conducting Hearings. In the case of such appointment, they shall act as the Presiding Officer in lieu of the Chair of the Hearing Panel. Should a Hearing Officer be appointed, they will assume the duties of the Presiding Officer as outlined in this Hearing Plan.

D. **Representation**
The Practitioner who requested the Hearing shall be entitled to be accompanied and represented at the Hearing by an attorney or another person of their choice. The Medical Executive Committee or the Board, depending on whose recommendation or action prompted the Hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses.

E. **Rights of Parties**

1. During the Hearing, each of the parties shall have the right to:
    a. Call and cross-examine available witnesses;
    b. Introduce relevant exhibits;
    c. Question any available witness on any matter relevant to the issues;
    d. Impeach any witness;
    e. Rebut any evidence;
    f. Request that the record of the Hearing be made by use of a court reporter or an electronic recording unit; and
    g. Submit a written summary after the close of the Hearing.
2. The parties may submit a written statement within ten (10) days after the close of the hearing or on a later date set by the Hearing Officer. Any written memorandum submitted by a party shall be delivered by that party on the same day to the other party.
3. The Practitioner may be called by the body whose decision prompted the hearing or the Hearing Panel and examined as if under cross-examination.
4. The Hearing Panel may question witnesses or call additional witnesses as the Hearing Panel, in its discretion, deems necessary.

F. **Pre-Hearing Discovery**

1. Rights of Inspection and Copying
    a. The Practitioner may request documents relevant to the reasons for the

Adverse Action recommended or taken that the Medical Staff has in its possession or under its control, other than information protected by the attorney-client privilege, and work product doctrine and subject to Section 8.8(F)(iii) herein.

b. The body whose decision prompted the hearing may request documents relevant to the Adverse Action recommended or taken that the Practitioner has in the Practitioner's possession or under the Practitioner's control other than information protected by the attorney-client privilege and work product doctrine.

c. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least five (5) days before the pre-hearing conference shall be good cause for a continuance of the hearing in accordance with Section 8.8(L), or such other discretionary action as may be warranted by the circumstances. All confidential documentary information disclosed shall be kept confidential and shall not be disclosed or used by the receiving party for any purpose not related to the hearing and appeal, in accordance with applicable law, and any stipulation signed by the Practitioner.

d. The disclosure of documentary information under these Bylaws is not intended to waive any privilege under applicable law.

2. The Practitioner, the Practitioner's attorney or other representative, or any other person acting on behalf of the Practitioner, shall not contact Hospital employees, Medical Staff leaders, Medical Staff committee members, or Board members concerning the subject matter of the hearing without prior approval of the Chief Executive Officer.

3. Limits on Discovery

    a. The right to request documents by either party does not extend to confidential Peer Review information concerning other Medical Staff Members, APPs, or Practitioners other than the Practitioner under review.

    b. The right to request documents by either party does not create or imply any obligation to modify or create documents in order to satisfy a request.

    c. The Hearing Officer or Presiding Officer shall consider and rule upon any request for documents and may impose any safeguard that the protection of the peer review process and fairness requires.

    d. The Hearing Officer or Presiding Officer shall rule on discovery disputes the parties cannot resolve and may impose any safeguard that the protection of the peer review process and fairness requires. Discovery requests may be denied based on relevancy. Discovery requests may also be denied or limited if the request is unreasonable, or unduly burdensome or expensive, or when necessary to protect any applicable privilege or based on patient privacy.

4. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment, or Clinical Privilege application review or during corrective action after requested by or on behalf of the Medical Staff, any committee, or Peer Review body. The Hearing Officer shall not admit such evidence unless the Practitioner demonstrates good cause for failing to comply with the earlier request.

G. **Pre-Hearing Exhibit Exchange**
The parties must exchange all exhibits to be offered into evidence at least fifteen (15) days before the pre-hearing conference. Failure to comply with this Section shall be good cause for the Hearing Officer to grant a continuance or to limit the introduction of any exhibits not provided to the other side in a timely manner. Objections and the basis for the objections to exhibits shall be submitted in writing to the Hearing Officer before the pre-hearing conference. All confidential exhibits exchanged shall be maintained as confidential and shall not be disclosed or used by the receiving party for any purpose not related to the hearing and appeal, unless otherwise in accordance with applicable laws and any stipulation signed by the Practitioner required by law. The exchange of exhibits under these Bylaws is not intended to waive any Privilege under applicable law.

H. **Pre-Hearing Witness Lists**

1. At least fifteen (15) days before the pre-hearing conference, each party shall furnish to the other a written list of the names and addresses of persons, in addition to those witnesses identified in the Hearing Notice under Section 8.2, who can reasonably be anticipated to give testimony or evidence in support of that party at the hearing, along with a general summary of their anticipated testimony.
2. Testimony of additional witnesses may be presented for purposes of rebuttal or other good cause shown. Failure to provide the name of a witness and a summary of their anticipated testimony at least fifteen (15) days before the pre-hearing conference date shall constitute good cause for the Hearing Officer to continue the hearing, exclude the witness's testimony, or take other action warranted by the circumstances.

I. **Procedure and Evidence**
The Hearing need not be conducted in strict conformance to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely on in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the Hearing Panel shall be with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The Panel shall also be entitled to consider all other information that can be considered, pursuant to the Medical Staff Documents, in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges. At the Presiding Officer's discretion, each party shall, prior to or during the Hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the Hearing record.

J. **Burden of Proof**
The body whose adverse recommendation or action occasioned the Hearing shall have the initial obligation to present evidence in support of its recommendation or action. Thereafter, the Practitioner shall present evidence. After all the evidence has been presented by both

sides, the Hearing Panel shall recommend in favor of the body whose action prompted the hearing unless it finds that the Practitioner has proved, by a preponderance of evidence, that the recommendation or action that prompted the hearing was arbitrary, unreasonable, capricious, or not supported by any rational basis.

K. **Record of Hearing**
A certified court reporter shall record the hearing proceedings and retain all exhibits. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of a copy of the transcript, if any, shall be borne by the requesting party. The Hearing Officer or Presiding Officer may require oral evidence be taken under oath.

L. **Postponement**
Request for a postponement of the Hearing shall be granted by the Presiding Officer, to a date agreeable to the Hearing Panel, only by stipulation between the parties or upon a showing of good cause, as determined by the Hearing Panel.

M. **Presence of Hearing Panel Members and Vote**
A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, that Hearing Panel member must certify that they have read the entire transcript of the portion of the Hearing from which they were absent.

N. **Recess and Adjournment**
The Hearing Panel may recess and reconvene the Hearing 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 both parties shall have the opportunity to submit a written statement at the close of the hearing. Following receipt of the written statements, the Hearing shall be closed. The Hearing Panel shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the Hearing shall be declared finally adjourned.

8.9. HEARING PANEL REPORT AND FURTHER ACTION

A. **Hearing Panel Report**
Within twenty (20) days after the final adjournment of the Hearing, the Hearing Panel shall prepare a written report of its findings and recommendations in the matter, as decided by a majority of the entire Hearing Panel, and shall forward the same, together with the Hearing record and all other documentation considered by it, for distribution to the Medical Executive Committee and the Practitioner.

B. **Action on Hearing Panel Report**
Within twenty (20) days after receipt of the written report of the Hearing Panel, the Medical Executive Committee or Board, depending on which body's recommendation or action prompted the Hearing, shall consider the report and affirm, modify or reverse its original recommendations or action in the matter. It shall transmit the result, together with the Hearing record, the report of the Hearing Panel and all other documentation considered, to the Chief Executive Officer. The Medical Executive Committee or Board, as the case may be, may also request an oral report by the Chair of the Hearing Panel during this thirty (30) day period.

C. **Notice and Effect of Result**
The Chief Executive Officer shall promptly send a copy of the Fair Hearing result to the

Practitioner by Special Notice, to the Chief of Staff, and to the Medical Executive Committee or to the Board, depending on which body's recommendation or action prompted the Hearing.

1. *Effect of Favorable Result*

    a. Adopted by the Medical Executive Committee
    If the Medical Executive Committee's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the Medical Executive Committee's recommendation in whole or in part, or by referring the matter back to the Medical Executive Committee for reconsideration. Any such referral back shall state the reasons for such referral, 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 within thirty (30) days. The Chief Executive Officer shall promptly notify the Practitioner by Special Notice, informing them of each action taken pursuant to this Subsection.

    b. Adopted by the Board
    If the Board's initial action on the Hearing report is favorable to the Practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

2. *Effect of Adverse Result*

    a. Adopted by the Medical Executive Committee
    If the result of the Medical Executive Committee continues to be an Adverse Action as defined in these Bylaws , the Practitioner shall be provided Special Notice of such advising of the Practitioner and of their right to request an appellate review by the Board as described in Section 8.10 below.

    b. Adopted by the Board
    If the result of the Board continues to be adverse to the Practitioner with respect to any recommendation or action listen in Sections A.1 and A.2, the Practitioner shall be provided special written notice of such, sent by certified mail, return receipt requested, advising of same and of their right to request an appellate review by the Board as described in Article 8.

8.10 APPELLATE REVIEW BY THE BOARD

A. Appellate Review Timeline

1. Within ten (10) calendar days after receipt of a notice of an adverse decision by the Board following a hearing, as provided above, an affected Member may, by written notice to the CEO and the other party by Special Notice, request an appellate review of the adverse decision by a committee of Board members.
2. If the affected Practitioner wishes an attorney to represent them at any such

appellate review appearance, the appellate review request shall so state.

3. The CEO will provide a copy of the appellate review request to the Chair of the Board.

B. Waiver Of Appeal

1. If appellate review is not requested within the prescribed time period and as prescribed above, the Member shall have waived any right of appeal.
2. If there is no appeal, the recommendation of the Hearing Panel shall be the final recommendation and action of the Medical Staff and shall be forwarded to the Board for final action. The Board shall adopt, modify, or reject the Hearing Panel's recommendation within sixty (60) days of the Hearing Panel's final recommendation or action. The Board's decision shall be forwarded to the Chief Executive Officer. Within ten (10) days of the Board's decision, the Chief Executive Officer shall send Notice of the Board's decision to the Member by Special Notice and to the Medical Executive Committee.

C. Time And Place For Appellate Review

1. In the event the appellate review request is received by the CEO within the ten (10) day period in Section 8.10 above, then within thirty (30) calendar days after receipt by the CEO of the appellate review request, the Chair of the Board will schedule a date, time and place for such review and will, through the CEO by Special Notice, notify the affected Member of the same ("Appeal Notice").
2. The appellate review shall commence within sixty (60) days from the date the transcript of the hearing is available or the date of the Appeal Notice, whichever is later. The time for appellate review may be extended by the Appellate Officer or Appeal Board for good cause.

D. Appeal Board

1. The Board Chair or designee may appoint an Appeal Board, which shall be composed of not less than three (3) members of the Board or independent third parties designated by the Board.
2. No member of the Appeal Board may be in direct economic competition with the Member, or have acted as accuser, investigator, witness, fact finder, initial decision maker, member of the Hearing Panel, or active participant in the consideration of the matter prior to the appeal. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board.
3. The Appeal Board may select an attorney to act as an Appellate Officer and have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article. The Appellate Officer shall not have a vote.
4. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

E. Appeal Board Procedure.

1. Each party shall have the right to be represented by an attorney or other representative designated by that party in connection with the appeal.
2. Each party shall have the right to present a written memorandum in support of the

party's position on appeal, with specific reference to the hearing transcript. The Appellate Officer may establish reasonable deadlines for the appealing party to provide a written memorandum and for the responding party to respond.

a. The Practitioner's statement should describe the reasons they believe the adverse decision of the Medical Executive Committee or the Board should be modified or reversed, consistent with the scope of review as set forth in Section 8.

b. The Medical Executive Committee or the Board may submit a written statement. The failure of the Medical Executive Committee or the Board to submit such a written response will not, in and of itself, constitute a basis for the Appellate Review Panel to recommend modifying or reversing the decision of the Medical Executive Committee or the Board (pursuant to Section 8), nor as a basis for the Board to decide to modify or reverse the decision of the Medical Executive Committee or the Board (pursuant to Section 9).

3. Each party has the right to personally appear and make an oral argument, not to exceed such time limits as may be established by the Appellate Officer. The appeal shall be deemed submitted when oral arguments are complete.
4. The proceeding by the Appeal Board shall be an appellate hearing based upon the record of the hearing before the Hearing Panel, the memoranda submitted by the parties, and the oral arguments of the parties.
5. The Appeal Board may, at the Appeal Board's sole discretion, consider evidence not available at the hearing, subject to a showing that such evidence could not have been made available in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Panel for the taking of further evidence and for a decision.
6. The Appeal Board may, at a time convenient to itself, deliberate outside the presence of the parties. Upon the conclusion of such deliberations, the appellate review shall be declared finally adjourned.

F. Decision

1. The party appealing shall have the burden of showing that the Hearing Panel's recommendation(s) is arbitrary, capricious,or not supported by credible evidence.
2. The Appeal Board may affirm, modify, reverse, or remand the matter for further review by the Hearing Panel or any other body designated by the Appeal Board; provided, however, that the Appeal Board may not take an Adverse Action that is more restrictive than the action recommended or taken by the body whose decision prompted the hearing.
3. Within ten (10) days after the appeal is adjourned, the Appeal Board shall prepare a written decision that specifies the reasons for the decision. If the decision of the Appeal Board differs from that of the Hearing Panel, then the written decision prepared by the Appeal Board shall include the findings of fact and conclusions that support the Appeal Board's decision.

4. A copy of the Appeal Board decision shall be forwarded to the CEO. Within ten (10) days of the Appeal Board decision, the CEO shall send a copy of the Appeal Board decision to the Member by Special Notice and to the Medical Executive Committee and the Board. The Appeal Board decision shall become the final action of the Board at the time of the Board's next meeting, unless the Board rejects, modifies, or returns the matter for further action.
5. The Appeal Board may remand the matter to the Hearing Panel, Hearing Officer, or any other body the Appeal Board designates for reconsideration or may refer the matter to the Board for review. If the matter is remanded for further review and recommendation, the further review shall be completed within thirty (30) days unless the parties agree otherwise or for good cause as determined by the Appeal Board.
6. The Appellate Officer may extend the time for the Appeal Board's decision not to exceed thirty (30) days.
7. If the Appeal Board fails to render a written decision within the time allowed under this Section 8.15, including any extension allowed by the Appellate Officer, the matter shall be referred to the Board for final decision, and the Appeal Board shall submit a written report describing evidence considered, the matters decided by the Appeal Board, if any, and the matters unresolved by the Appeal Board, including a description of the views of the Appeal Board members.
8. The Board shall make a final decision in accordance with this Article 8 within sixty (60) days of receipt of the Appeal Board's written decision. Within ten (10) days of the Board's final decision, the Chief Executive Officer shall send the Board's final decision to the Member by Special Notice and to the Medical Executive Committee.

G. Review Limited To One Hearing And One Appellate Review
Notwithstanding any other provision of these Bylaws, no affected Member shall be entitled as a right to more than one (1) hearing and one (1) appellate review on any matter which shall have been the subject of an Adverse Action by the Medical Executive Committee, the Board or both.

ARTICLE 9: CONFIDENTIALITY, IMMUNITY AND RELEASES

9.1. AUTHORIZATIONS AND CONDITIONS

By applying for or exercising Clinical Privileges within the Hospital, an applicant:

A. Authorizes Representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing upon, or reasonably believed to bear upon the applicant's professional ability and qualifications;

B. Authorizes persons and organizations to provide information concerning such applicant to the Medical Staff;

C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative of the Medical Staff or Hospital who acts in accordance with the Medical Staff Documents;

D. Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff Membership or Clinical Privileges, the continuation of such Membership and to the exercise of Clinical Privileges or specified patient services at the Hospital;

E. Acknowledges that by submitting an application for Membership or Clinical Privileges, by accepting appointment or reappointment or Clinical Privileges, or by exercising Clinical Privileges including temporary privileges, the individual specifically agrees to be bound by the Medical Staff Documents, including the provisions of this Article, during the processing of the application and at any time thereafter, and such provisions shall continue to apply during the Membership term or term of Clinical Privileges; and

F. Agrees, authorizes and/or acknowledges any and all further conditions as more specifically detailed in the Medical Staff Documents and applicable credentialing and application forms.

9.2. CONFIDENTIALITY OF INFORMATION

Information submitted, collected or prepared by any Representative of the Hospital or any other health care facility or organization or Medical Staff shall be confidential and protected from discovery to the fullest extent permitted by law if collected for the purpose of assessing, reviewing, evaluating, monitoring or improving the quality and efficiency of health care provided, reducing morbidity and mortality, evaluating current clinical competence and qualifications for appointment or Clinical Privileges, contributing to teaching or clinical research or determining that health care services were indicated or were performed in compliance with the applicable standard of care. Dissemination of such information shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Executive Committee or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee. Such confidentiality shall extend to members of the Medical Staff, Advanced Practice Providers, Allied Health Professionals, the Chief Executive Officer, Administrative officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release, or act upon such information.

9.3. BREACH OF CONFIDENTIALITY

Because effective peer review, risk management, credentialing and performance improvement activities must be based on free and candid discussions, any breach of confidentiality regarding the discussions or deliberations at Medical Staff meetings or Committees meetings is deemed to be unprofessional conduct disruptive to the operations of the Hospital and the effective delivery of quality patient care. Such breach shall subject the individual responsible to disciplinary action under the Medical Staff Documents, or Hospital policies and procedures.

9.4. IMMUNITY FROM LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation, or disclosure.

9.5. ACTIVITIES AND INFORMATION COVERED

Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given, or made in connection with or for, or on behalf of, any activities of the Medical Staff, Advanced Practice Providers, Allied Health Professionals, or the Hospital or any other healthcare entity/ provider including, without limitation, those relating to:

A. Applications for Membership or for Clinical Privileges;

B. Ongoing or periodic performance appraisals or reviews for reappointment or for renewal or revisions to Clinical Privileges;

C. Corrective action, including suspension or revocation of Medical Staff Membership or Clinical Privileges;

D. Hearing and appellate review proceedings;

E. Resource or utilization management review; and

F. Any other Hospital or Medical Staff Committee activity related to improving the quality of patient care, evaluating/monitoring clinical competence or professional conduct, and all other peer review and risk management activities as defined by K.S.A. § 65- 4915 and K.S.A. § 65-4923 et seq. Such matters may concern, involve, or relate to, without limitation, an individual's professional qualifications, clinical competence, character, fitness to practice, physical or mental condition, ethical or moral standards, or any other matter that may affect patient care.

9.6. RELEASES

In the furtherance and in the interest of providing quality patient care, each applicant for Membership or Clinical Privileges, and each Medical Staff Member or individual granted Clinical Privileges shall, upon request, execute general and specific releases and authorizations in accordance with the express provisions and intent of this Article. Execution of such releases and authorizations will not be deemed a prerequisite to the effectiveness of this Article.

9.7. INDEMNIFICATION

Members of the Medical Staff, Advanced Practice Providers, and Allied Health Professionals when acting in good faith without malice on behalf of the Hospital in the performance of Peer Revuew activities pursuant to the Medical Staff Documents, or other professional review activities undertaken on behalf of the Hospital enumerated in the Medical Staff Bylaws, shall be indemnified by the Hospital.

ARTICLE 10: ADVANCED PRACTICE PROVIDERS AND ALLIED HEALTH PROFESSIONALS

10.1 OVERVIEW

A. Advanced Practice Providers and Allied Health Professionals are not Members of the Medical Staff and are not eligible to apply for or be granted Medical Staff Membership. Accordingly, APPs and AHPs are not entitled to serve as Medical Staff Officers, Department Chairs, or Medical Staff committee chairs. Except as otherwise permitted in these Bylaws, APPs and AHPs are not entitled to vote on Medical Staff matters.

10.2. ADVANCED PRACTICE PROVIDERS

A. APPs Generally
The Medical Staff Credentialing Policy and the Hospital Advanced Practice Providers Policy details the types and categories of Advanced Practice Providers who may apply and be granted Clinical Privileges at the Hospital; the qualifications required to be eligible for such Clinical Privileges; the process for submitting applications; and the requirements, obligations, and prerogatives of Allied Health Professionals credentialed by the Medical Staff.

B. Credentialed without Privileges
APPs that are otherwise qualified for Clinical Privileges but have no patient encounters in the Hospital in a twelve-month period may be credentialed by the Medical Staff Office pursuant to the Medical Staff Documents but are not granted Clinical Privileges. APPs who are credentialed without Privileges may not serve on Medical Staff committees, attend meetings, or vote on any Medical Staff matters.

10.3. ALLIED HEALTH PROFESSIONALS

A. The Medical Staff Credentialing Policy and the Hospital Allied Health Professionals Policy delineate the types and categories of Allied Health Professionals who may apply and be granted Clinical Privileges at the Hospital; the qualifications required to be eligible for such Clinical Privileges; the process for submitting applications; and the requirements, obligations, and prerogatives of Allied Health Professionals credentialed by the Medical Staff.

ARTICLE 11: ADOPTION AND AMENDMENT

11.1. MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff Bylaws shall be adopted upon majority vote of the Medical Staff and the Medical Executive Committee and shall become effective upon approval of the Board. The Medical Staff Rules and Regulations, Credentialing Policy, and Policies shall be adopted by the Medical Executive Committee,

acting on behalf of the Medical Staff, and shall become effective on approval of the Board. The Medical Staff Documents shall not conflict with the Bylaws of the Board of Directors.

Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws, Credentialing Policy, Medical Staff Rules and Regulations, or Policies. The Board of Directors shall act in accordance with the Medical Staff Documents as approved, upon recommendation of the organized Medical Staff or as recommended by the Medical Executive Committee upon delegation of such function to the Medical Executive Committee by the Medical Staff. The Board shall uphold the Medical Staff Bylaws, Rules and Regulations and policies that have been approved by the Board.

11.2. EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method of initiation, adoption, amendment or repeal of the Medical Staff Documents.

11.3. AMENDMENT OF THE MEDICAL STAFF BYLAWS

A. The Medical Staff Bylaws may be amended or repealed in whole or in part, by the Medical Staff, after submission of the proposed changes to, or upon the initiative of, the Medical Staff Bylaws Committee followed by approval of the Medical Executive Committee, the Medical Staff, and the Board and/or in accordance with these Bylaws. In addition, the Medical Staff may propose amendments to these documents directly to the Board, in accordance with Article 11.

B. Prior to vote by the Medical Staff, the proposed changes will be posted in an area at the Hospital conspicuous to and frequented by members of the Medical Staff at least fourteen (14) days in advance of the vote. Posting may be accomplished by mail, email, or facsimile to Active Medical Staff Members, or by presentation at a regular or special meeting of the Medical Staff. The posting shall contain the exact wording of the proposed change(s) and the existing language, if any comparable wording exists.

C. To be adopted at a regular or special meeting of the Medical Staff, any amendment shall require an affirmative vote of greater than fifty (50) percent of the Active Medical Staff Members present and voting. Voting by proxy shall not be allowed. Amendments so adopted shall be effective when approved by the Board.

D. The Medical Executive Committee may also authorize the use of a mail or electronic ballot for voting by the general Medical Staff. In such case, the proposed changes must be presented to the staff eligible to vote at least fourteen (14) days prior to the deadline for return of the ballot. Posting may be accomplished by mail, email, or facsimile or by presentation at a regular or special meeting of the Medical Staff. To be adopted, an amendment by mail or electronic ballot shall require an affirmative vote of the majority of ballots returned, so long as the proposed amendment is voted on by at least fifty (50) percent of the Staff eligible to vote. Voting by proxy shall not be allowed. Amendments so adopted shall be effective when approved by the Board.

11.4. ADOPTION OF SUPPLEMENTAL MEDICAL STAFF DOCUMENTS

The Medical Executive Committee shall adopt Rules and Regulations, Credentialing Policy, and any other Policies and procedures which may be necessary, to implement more specifically the general principles of conduct found in these Bylaws. The Rules and Regulations, Credentialing Policy, and any other policies and procedures adopted by majority vote of the Medical Executive Committee, shall set forth standards of practice that are to be required of each physician and dentist in the Hospital and shall act as an aid to evaluating performance and compliance with such standards. Such Rules and Regulations, Credentialing Policy, and Policies shall become effective immediately following approval by the Board, unless otherwise indicated. They shall have the same force and effect as the Bylaws.

11.5. AMENDMENT OF THE SUPPLEMENTAL MEDICAL STAFF DOCUMENTS

A. Process and Notice and Comment Period for Medical Executive Committee Amendment to the Rules.

    1. The Rules and Regulations, Credentialing Policy, and Medical Staff Policies (collectively, the "Supplemental Documents") adopted by the Medical Executive Committee and approved by the Board, may be amended by the Medical Executive Committee and Board.
    2. Prior to amending a Supplemental Document, the Medical Executive Committee must first communicate the proposed amendment to the Medical Staff for review and comment. This review and comment opportunity shall be accomplished by circulating the proposed amendment to all Medical Staff Members at least thirty (30) days prior to the scheduled Medical Executive Committee meeting, together with instructions on how interested Members may communicate their comments to the Medical Executive Committee. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to the Medical Executive Committee's action on the proposed changes or additions.

B. Process for Medical Staff Amendment to the Supplemental Documents.
As an alternative to the Medical Executive Committee proposing an amendment to a Supplemental Documents, the members of the Active staff may propose an amendment to the Supplemental Document by a petition signed by at least forty percent (40%) of the members of the Active staff. Such petition shall first be submitted to the Medical Executive Committee for its consideration and approval. The Medical Executive Committee shall act on such petition at its next scheduled meeting.

C. Medical Executive Committee Approval of Amendments Proposed By Medical Staff.
The Medical Executive Committee's approval is required on all amendments to the Supplemental Documents, unless the petition described in Subsection B above was generated by at least two-thirds (2/3) of the members of the Active staff, in which case, if the Medical Executive Committee does not approve the proposed amendment, the Medical Executive

Committee shall give the Medical Staff notice within ten (10) days of its decision, and the Active staff members may choose to present the proposed amendment to the Supplemental Document directly to the Board for approval. If the proposed amendment was not generated by a petition of at least two-thirds (2/3) of the members of the Active staff and the Medical Executive Committee fails to approve the proposed amendment, the proposed amendment shall be submitted to the Active members of the Medical Staff for a formal vote, and if approved by two-thirds (2/3) of the Members of the Active staff, shall be forwarded to the Board for approval and implementation.

D. Board Approval of Amendments to the Rules.
Following approval by the Medical Executive Committee, the presentation of an amendment to a Supplemental Document by petition of at least two-thirds (2/3) of the Active Members of the Medical Staff, or the approval of an amendment to the Supplemental Document proposed through a petition as described in Subsection C, the proposed amendments shall be forwarded to the Board for approval. The amendment to the Supplemental Document shall become effective immediately following approval by the Board, unless otherwise indicated, or automatically within sixty (60) days if no action is taken by the Board.

E. Urgent Amendment to the Rules.
In cases of a documented need for an urgent amendment to a Supplemental Document in order to comply with a law or regulation, the Medical Executive Committee may provisionally adopt such an amendment and forward it to the Board for approval and immediate implementation without prior notification of the Medical Staff. The Medical Staff will then be immediately notified by the Medical Executive Committee of the provisionally adopted and approved Supplemental Document. The Medical Staff shall then have the opportunity for retrospective review of and comment on the provisional amendment. The Medical Staff may, by a petition signed by at least two-thirds (2/3) of the Active staff Members require that the amendment be reconsidered; provided, however, the approved amendment shall remain effective until such time as a superseding amendment meeting the requirements of the law or regulation has been approved.

11.6 CLINICAL SERVICE POLICIES

Subject to the approval of the Medical Executive Committee and the Board, each Service may formulate and implement other policies and procedures necessary for the conduct of business and discharge of its responsibilities. Such other policies and procedures shall not be inconsistent with the Medical Staff Documents or Hospital policies/procedures.

11.7. TECHNICAL AND EDITORIAL MODIFICATIONS

The Medical Executive Committee may correct typographical, spelling, grammatical, numbering, or other obvious technical or editorial errors in the Medical Staff Documents. The action to make such technical or editorial modification may be taken by motion and acted upon in the same manner as any other motion before the Executive Committee. After approval, the substance of such amendments shall be communicated to the Medical Staff and the Board. Such amendments shall be effective immediately and shall be permanent approval by the Board.

11.8. REVIEW

The Medical Staff Bylaws shall be reviewed at least annually by the Board and the Medical Executive Committee, and amended when appropriate.

Approval Signatures

Step Description	Approver	Date
OMCI Policy & Procedure Committee	Melody Brownfield: Exec Asst to SVP or Div Chief	07/2025
OMCI Board of Directors	Melody Brownfield: Exec Asst to SVP or Div Chief	07/2025
Medical Staff	Traci Lewin: SW KC Mkt Medical Education Coord	07/2025
Medical Executive Committee	Leslie Johnston: SW KC Mkt Medical Staff Coordinator	07/2025

Applicability

UKHS: SW - Olathe Hospital