MEDICAL STAFF BYLAWS

OF

BAPTIST MEDICAL CENTER EAST

BAPTIST MEDICAL CENTER SOUTH

PRATTVILLE BAPTIST HOSPITAL


Revised:
October 2004: Section 6
October 2005: Section 3.4.n; Section 5.2.4; Section 12.4.1 & 8.3.1d
October 2006: Preamble; Section 4; Section 6; Section 9; Section 10; Section 11; Section 16
October 2007: Preamble; Section 3; Section 4; Section 5; Section 6; Section 7; Section 8; Section 9;
Section 10; Section 11; Section 12; Section 15; Section 16; Section 17
November 2008: Section 4; Section 8; Section 11
April 2011: Preamble; Section 3.3.1.b; Section 3.4.b,p,q; Section 4.4.3.i; Section 5.2.4; Section 5.5;
Section 6.1.8; Section 6.2; Section 6.3.1; Section 6.3.8; Section 8.3.d; Section 8.4.3.f;
Section 8.7; Section 9.4.s-w; Section 10.4; Section 10.7; Section 11.2.d,q; Section 11.4;
Section 11.5; Section 11.6; Section 11.19; Section 16.4.7.a; Section 16.4.; Section 17.7.7;
Article 19; Section 20.1; Flowchart; Article 21; Article 22
March 2012: Section 8.4.4, Section 9.3.5.d., Section 10.3.3, Section 10.3.4., Section 11.4.1b, Section
11.19, Section 12.1, Section 18.1, Section 18.2.1, Article 23
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARTICLE I</strong></td>
</tr>
<tr>
<td><strong>ARTICLE II</strong></td>
</tr>
<tr>
<td><strong>ARTICLE III</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>ARTICLE IV</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>ARTICLE V</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>ARTICLE VI</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>ARTICLE VII</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>ARTICLE VIII</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td><strong>SECTION</strong></td>
</tr>
<tr>
<td>ARTICLE IX</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>9.1</td>
</tr>
<tr>
<td>9.2</td>
</tr>
<tr>
<td>9.3</td>
</tr>
<tr>
<td>9.4</td>
</tr>
<tr>
<td>9.5</td>
</tr>
<tr>
<td>9.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARTICLE X</th>
<th>MEDICAL STAFF OFFICERS</th>
<th>32-34</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Officers</td>
<td>32</td>
</tr>
<tr>
<td>10.2</td>
<td>Qualifications</td>
<td>32</td>
</tr>
<tr>
<td>10.3</td>
<td>Elections of Officers</td>
<td>32</td>
</tr>
<tr>
<td>10.4</td>
<td>Term of Office</td>
<td>33</td>
</tr>
<tr>
<td>10.5</td>
<td>Vacancies</td>
<td>33</td>
</tr>
<tr>
<td>10.6</td>
<td>Duties of Officers</td>
<td>33-34</td>
</tr>
<tr>
<td>10.7</td>
<td>Removal of Officers</td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARTICLE XI</th>
<th>MEDICAL STAFF COMMITTEES</th>
<th>34-41</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>General</td>
<td>34</td>
</tr>
<tr>
<td>11.2</td>
<td>Standing Committees</td>
<td>34-35</td>
</tr>
<tr>
<td>11.3</td>
<td>Physician Council</td>
<td>35</td>
</tr>
<tr>
<td>11.4</td>
<td>Campus Medical Executive Committee</td>
<td>35-36</td>
</tr>
<tr>
<td>11.5</td>
<td>Credentials Committee</td>
<td>36-37</td>
</tr>
<tr>
<td>11.6</td>
<td>Quality Assurance / Quality Improvement Committee</td>
<td>37</td>
</tr>
<tr>
<td>11.7</td>
<td>Utilization Review / Medical Records Committee</td>
<td>37-38</td>
</tr>
<tr>
<td>11.8</td>
<td>Pharmacy &amp; Therapeutics Committee</td>
<td>38</td>
</tr>
<tr>
<td>11.9</td>
<td>Infection Control Committee</td>
<td>38</td>
</tr>
<tr>
<td>11.10</td>
<td>Bylaws Committee</td>
<td>38-39</td>
</tr>
<tr>
<td>11.11</td>
<td>Therapeutic Termination of Pregnancy Committee</td>
<td>39</td>
</tr>
<tr>
<td>11.12</td>
<td>OR Advisory Committee</td>
<td>39-40</td>
</tr>
<tr>
<td>11.13</td>
<td>Radiation Safety Committee</td>
<td>40</td>
</tr>
<tr>
<td>11.14</td>
<td>Institutional Review Committee</td>
<td>40</td>
</tr>
<tr>
<td>11.15</td>
<td>Ethics Committee</td>
<td>40-41</td>
</tr>
<tr>
<td>11.16</td>
<td>GI Advisory Committee</td>
<td>41</td>
</tr>
<tr>
<td>11.17</td>
<td>Blood Utilization Committee</td>
<td>41</td>
</tr>
<tr>
<td>11.18</td>
<td>Trauma Systems Committee</td>
<td>42</td>
</tr>
<tr>
<td>11.19</td>
<td>Physician Information Technology (IT) Committee</td>
<td>42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARTICLE XII</th>
<th>MEETINGS</th>
<th>43</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Annual Meeting</td>
<td>43</td>
</tr>
<tr>
<td>12.2</td>
<td>Special Meetings</td>
<td>43</td>
</tr>
<tr>
<td>Section</td>
<td>Article</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>12.3</td>
<td>Clinical Department Meetings</td>
<td>43</td>
</tr>
<tr>
<td>12.4</td>
<td>Attendance at Meetings</td>
<td>43</td>
</tr>
<tr>
<td>12.5</td>
<td>Quorum</td>
<td>43</td>
</tr>
<tr>
<td>12.6</td>
<td>Official Medical Staff Year</td>
<td>43</td>
</tr>
<tr>
<td><strong>ARTICLE XIII</strong></td>
<td><strong>DUES</strong></td>
<td>44</td>
</tr>
<tr>
<td><strong>ARTICLE XIV</strong></td>
<td><strong>IMMUNITY FROM LIABILITY</strong></td>
<td>44-45</td>
</tr>
<tr>
<td><strong>ARTICLE XV</strong></td>
<td><strong>LIMITED LICENSED PROFESSIONALS</strong></td>
<td>45</td>
</tr>
<tr>
<td>15.1</td>
<td>Definition</td>
<td>45</td>
</tr>
<tr>
<td>15.2</td>
<td>Appointment/Reappointment</td>
<td>45</td>
</tr>
<tr>
<td>15.3</td>
<td>Limits of Privileges</td>
<td>45</td>
</tr>
<tr>
<td>15.4</td>
<td>Limits of Activities</td>
<td>45</td>
</tr>
<tr>
<td>15.5</td>
<td>Temporary Approval</td>
<td>45</td>
</tr>
<tr>
<td><strong>ARTICLE XVI</strong></td>
<td><strong>SPECIAL LIMITED STAFF</strong></td>
<td>46-47</td>
</tr>
<tr>
<td>16.1</td>
<td>Membership</td>
<td>46</td>
</tr>
<tr>
<td>16.2</td>
<td>Categories of Members</td>
<td>46</td>
</tr>
<tr>
<td>16.3</td>
<td>Qualifications</td>
<td>46-47</td>
</tr>
<tr>
<td>16.4</td>
<td>Appointment/Reappointment</td>
<td>47-48</td>
</tr>
<tr>
<td>16.5</td>
<td>Temporary Approval</td>
<td>48</td>
</tr>
<tr>
<td>16.6</td>
<td>Limits of Activities</td>
<td>48</td>
</tr>
<tr>
<td><strong>ARTICLE XVII</strong></td>
<td><strong>ALLIED HEALTH PROFESSIONALS</strong></td>
<td>49-52</td>
</tr>
<tr>
<td>17.1</td>
<td>Categories of Members</td>
<td>49</td>
</tr>
<tr>
<td>17.2</td>
<td>Nature of Privileges</td>
<td>49</td>
</tr>
<tr>
<td>17.3</td>
<td>Qualifications</td>
<td>49-50</td>
</tr>
<tr>
<td>17.4</td>
<td>Appointment &amp; Granting Privileges</td>
<td>50</td>
</tr>
<tr>
<td>17.5</td>
<td>Temporary Approval</td>
<td>50</td>
</tr>
<tr>
<td>17.6</td>
<td>Limits of Activities</td>
<td>50</td>
</tr>
<tr>
<td>17.7</td>
<td>Appointment/Reappointment</td>
<td>50-52</td>
</tr>
<tr>
<td><strong>ARTICLE XVIII</strong></td>
<td><strong>HOSPITAL BASED PHYSICIANS</strong></td>
<td>52</td>
</tr>
<tr>
<td>18.1</td>
<td>Exclusive Contracts for Provision of Radiology, Anesthesiology, Pathology &amp; Emergency Medicine</td>
<td>52</td>
</tr>
<tr>
<td>18.2</td>
<td>Exclusivity Contracts</td>
<td>52</td>
</tr>
<tr>
<td>18.3</td>
<td>Loss of Privileges</td>
<td>52</td>
</tr>
<tr>
<td><strong>ARTICLE XIX</strong></td>
<td><strong>RULES &amp; REGULATIONS</strong></td>
<td>53</td>
</tr>
<tr>
<td><strong>ARTICLE XX</strong></td>
<td><strong>BYLAW CHANGES</strong></td>
<td>53-55</td>
</tr>
<tr>
<td>*Flow Diagram for Bylaw Changes</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td><strong>ARTICLE XXI</strong></td>
<td><strong>MEDICAL STAFF CREDENTIALING POLICIES</strong></td>
<td>57</td>
</tr>
<tr>
<td><strong>ARTICLE XXII</strong></td>
<td><strong>CONFLICT RESOLUTION</strong></td>
<td>57-58</td>
</tr>
</tbody>
</table>
WHEREAS, the Health Care Authority for Baptist Health, an affiliate of UAB Health System (hereinafter referred to as Baptist Health), is a not-for-profit corporation organized under the laws of the State of Alabama; and

WHEREAS, its purpose is to extend the healing ministry of Christ by providing comprehensive health care, with emphasis on care of the total person, through the medium of coordinated modern facilities and health care programs; and

WHEREAS, the Health Care Authority for Baptist Health, an affiliate of UAB Health System, Board of Directors (hereinafter referred to as the Board or Governing Board) has authorized the formation of a Medical Staff to carry out the functions delegated to the Medical Staff by the Board in conformity with these Bylaws.

NOW THEREFORE, the physicians and oral surgeons practicing at Baptist Health do constitute three (3) Medical Staffs in conformity with these Bylaws and their campus specific Rules & Regulations:

These Bylaws are adopted in order to provide for the organization of the separate Medical Staffs at Baptist Medical Center East (BMCE), Baptist Medical Center South (BMCS) and Prattville Baptist Hospital (PBH). These Bylaws provide a framework for self-governance at each campus in order to permit the Medical Staffs to discharge their responsibilities in matters involving patient safety and the quality of medical care, and to govern the orderly discharge of these purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board, and relations with applicants to and members of the Medical Staffs. These Bylaws, when adopted by the Health Care Authority for Baptist Health, an affiliate of UAB Health System, Board of Directors, create a mutually binding agreement between the Medical Staffs and the Board.

The Medical Staff bylaws, rules and regulations, credentialing policies, Governing Board bylaws and hospital clinical policies are intended to be compatible with each other and are compliant with law and regulations.

ARTICLE I: NAME

The name of these organizations shall be Baptist Medical Center East Medical Staff, Baptist Medical Center South Medical Staff and the Prattville Baptist Hospital Medical Staff.

ARTICLE II: PURPOSES

The purposes of this organization are to extend the healing ministry of Christ by providing health care through coordinated facilities and programs and to bring together members of BMCE, BMCS and PBH Medical Staffs under common Bylaws to discharge the functions of the Medical Staff as set forth in these Bylaws.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

No physician or other qualified practitioners, including those in a medical administrative position by virtue of a contract with a hospital, shall admit or provide medical or health-related services to patients in that hospital unless he or she has requested and received appointment to the Medical Staff of that hospital or has requested and received special temporary privileges at that hospital in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws. Membership is not a right of any person. Every qualified practitioner who seeks or enjoys Medical Staff membership must continuously meet and demonstrate to the satisfaction of the Medical Staff and the Board the qualifications, standards and requirements set forth in these Bylaws or as a condition of receiving same
3.2 **Nondiscrimination**
No aspect of Medical Staff membership or particular privileges shall be denied on the basis of sex, race, age, creed, color, national origin or religion.

3.3 **Qualifications for Membership**

3.3.1 **General Qualifications**
A candidate shall be eligible for membership on the Medical Staff only if he/she satisfies all the following qualifications. Only physicians (an individual with an M.D. or D.O. degree who is fully licensed by the Medical Licensure Commission to practice medicine or osteopathy in the State of Alabama) and oral surgeons licensed to practice in the State of Alabama shall be considered for membership on the Medical Staff. To be considered, a physician or oral surgeon must:

a. document his/her: (1) current and valid license to practice his/her respective profession in the State of Alabama; (2) education and relevant training by being a graduate of an approved and accepted medical, osteopathic, or dental school, and have completed a residency program approved by the Accreditation Council for Graduate Medical Education or other similar accrediting body; (3) experience, ability, and current competence to perform the requested privilege(s); (4) appropriate professional and clinical judgment, (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care, treatment and services; (6) current and past malpractice claims experience and disciplinary experience, and (7) continuing medical education and information regarding board certifications, board eligibility and dates of pending exams;

b. be board certified or eligible, if applying for initial membership privileges, as defined by their respective accrediting body. Board eligible physicians must successfully complete their board examinations within the time frame mandated by their individual accrediting body. Board certification must be from a Board recognized by the American Board of Medical Specialties or the American Osteopathic Association. After January 1, 2012, all initial applicants will be required to obtain and maintain certification in the specialty for which they are boarded. If previously grandfathered by the hospital board or left in good standing then previous members of the staff may be exempt from the above criteria.

c. adhere to the ethics of his/her respective professions;

d. be able to work with others so as not to adversely affect patient care and so as to carry out professional responsibilities;

e. keep as confidential, as required by law, all information or records received in the physician-patient relationship;

f. be willing to participate in and properly discharge those responsibilities delineated by the Medical Staff;

g. maintain a practice and residence within a reasonable distance to the Baptist Health hospital at which he or she practices in order to maintain admitting privileges and provide timely continuous care of his/her patients; each clinical department is responsible for defining time and/or distance per specialty in the campus Rules & Regulations;

h. provide evidence of professional liability insurance with a minimum coverage as established in the campus Rules and Regulations, except for Active Duty Military Staff and medical staff members employed by the federal government to provide patient care, acting in the line and scope of their employment, who are covered under the Federal Tort Claims Act (FTCA).

i. be deemed to possess basic qualifications for membership in the Medical Staff, if any, adopted by the Medical Staff from time to time, except for the honorary staff category, in which case these criteria shall only apply as deemed individually applicable by the Medical Staff.

3.3.2 The qualifications for Medical Staff membership may be modified from time to time through an amendment to these Bylaws.

3.3.3 Initial appointments, reappointments, and revocation of appointments to the Medical Staff shall be made by the Board only after there has been a recommendation from the respective campus Medical Executive Committee.

3.3.4 All members of the Medical Staff agree to participate actively in their hospital’s quality assurance programs as approved by the campus Medical Executive Committee, in accordance
3.4 **Basic Responsibilities of Membership**

Each member of the Medical Staff shall:

a. provide patients with the quality of care meeting the professional standards of the Medical Staff of the hospital;

b. abide by the Medical Staff Bylaws and Rules & Regulations as well as the Baptist Health Code of Conduct;

c. discharge in a responsible manner such reasonable responsibilities and assignments imposed upon the member by the Medical Staff, by virtue of Medical Staff membership, including committee assignments;

d. prepare and complete in timely fashion medical records for all the patients to whom the member provides care in the hospital;

e. abide by the lawful ethical principles of his/her profession and avoid acts constituting unprofessional conduct under licensing laws and regulations of the State of Alabama or fraud or other actionable conduct potentially subject to penalty or criminal sanction under federal and state laws and regulations;

f. be encouraged to aid in any Medical Staff approved educational programs for medical students, interns, resident physicians, staff physicians and oral surgeons, nurses and other approved medical personnel;

g. work with members of the medical staff, nurses, hospital Administration and other hospital personnel so as not to adversely affect patient care;

h. make appropriate arrangements for coverage for his/her patients as determined by the Medical Staff;

i. not engage in any acts of discrimination prohibited by state or federal law;

j. participate in continuing education programs as determined by the Medical Staff and as required by the State Board of Medical Licensure;

k. participate in Emergency Department coverage pursuant to EMTALA regulations.

l. providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to these Bylaws, and those which are the subject of a hearing pursuant to these Bylaws;

m. pay all Medical Staff dues and assessments as may be set forth in these Bylaws or in the Rules & Regulations of the Medical Staff;

n. inform the campus Medical Executive Committee and the Credentials Committee within 30 days of final action:

   (1) any final action taken by any other hospital or health care institution to limit, restrict, deny, revoke, or suspend the member’s staff membership or clinical privileges;

   (2) any final limitations, restrictions, suspension, or revocation of the member’s professional license issued by the State of Alabama;

   (3) any final action taken by a medical licensing entity, state or county medical society, or hospital involving written sanction (public or private), fine, probation, or suspension relating to personal actions or quality assurance issues; and,

   (4) any final limitation, restriction, suspension, or revocation of the member’s narcotics license.

o. participate in the Medical Staff peer review process.

p. cooperate with the Ongoing Professional Practice Evaluation.

q. cooperate with the Focused Professional Practice Evaluation.

**ARTICLE IV: APPOINTMENT & REAPPOINTMENT**

4.1 **General**

Except as otherwise specified herein, no physician or oral surgeon (including practitioners engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that physician or oral surgeon applies for and receives appointment to the Medical Staff. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to review these Bylaws and agrees that throughout any period of membership he or she will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules &
Regulations of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws. Appointment or reappointment to the Medical Staff is made for a period not to exceed two years. Except as defined in Article 18.1 in the case of exclusive contracts, the termination, granting, continuation or restriction of Medical Staff membership and privileges based on economic criteria unrelated to clinical qualifications, professional responsibilities or quality of care is prohibited, with the exception of statutory, regulatory, or judicial requirements, or other exceptions which may be defined in the Medical Staff Bylaws.

4.2 Burden of Producing Information
In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. The burden may include submission to a medical or psychological examination, at the applicant’s expense, if deemed appropriate by the campus Medical Executive Committee, which may select the examining physician or psychologist.

4.3 Application Process
4.3.1 Upon receipt of a request in writing or by telephone, if criteria for Medical Staff membership has been met, the Credentials Verification Office (CVO) shall send the potential applicant the following:
   a. a letter outlining documentation required to be submitted with the application
   b. the system Medical Staff Application
   c. clinical privileges specific to each campus where the applicant is seeking staff membership
   d. a copy of the joint Medical Staff Bylaws
   e. a copy of the campus-specific Rules & Regulations
4.3.2 Once the completed application form is returned, the review process will begin.

4.4 Application for Appointment
4.4.1 All applications for Medical Staff membership must be typed or printed, signed by the applicant and submitted to the CVO with the application fee. The application must be submitted on the form furnished by Baptist Health. Any revision to the application form shall be subject to approval by both campus Medical Executive Committees.
4.4.2 A complete application shall:
   a. include a statement that the applicant has read the Medical Staff Bylaws and Rules & Regulations, and that he/she agrees to be bound by their terms if granted membership, and in all matters relating to consideration of the application, whether or not membership is granted;
   b. include detailed information concerning the applicant’s professional qualifications, including but not limited to those basic qualifications required for staff membership as stated in Section 3.3 above;
   c. specify the campus or campuses to which the application pertains.
   d. include the clinical privileges for which the applicant wishes to be considered;
   e. include a full summary of the applicant’s medical education, including the name, dates and locations of all medical school(s) attended, internships, residencies, fellowships or other specialty training, etc.;
   f. include a complete listing of specialty board certification, and licenses, indicating the granting authority and dates;
   g. include information regarding any previous adverse actions or currently pending challenges with respect to the applicant’s professional licensure or registration, any malpractice judgment(s) or claims against the applicant, any voluntary or involuntary loss or denial of membership in any professional organization and/or any voluntary or involuntary loss or denial of Medical Staff membership or privileges at any other hospital;
   h. include information regarding any voluntary or involuntary termination of Medical Staff membership, and/or any voluntary or involuntary limitation, reduction, or loss of clinical privileges at any other hospital;
i. include a copy of current Alabama medical license, professional liability insurance in the amount required by Article 3.3.1.h of these Bylaws, and copies of current federal and Alabama narcotics certifications;

j. include the names and addresses of individuals who have had extensive experience observing and working with the applicant, sufficient to assess the applicant’s professional competence and moral and ethical character;

k. signify that the burden is on the applicant to meet all requirements of the application process and to show that the applicant is qualified for Medical Staff membership and for the clinical privileges requested;

l. attest to or provide documentation that the applicant has no physical or mental limitations which would impair his/her ability to render quality patient care; and

m. provide any other information and/or documentation requested through the application, or requested in connection with the processing or review of such application.

4.4.3 By applying for appointment to the Medical Staff, each applicant:

a. signifies his/her willingness to appear for an interview in regard to his/her application;

b. authorizes the hospital and its representatives, including, without limitation, the Medical Staff and its representatives, to consult with members of the Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character, and ethical qualifications;

c. consents to the hospital’s inspection of all records and documents that may be material to an evaluation of (1) his/her professional qualifications, (2) his/her competence to carry out the clinical privileges he/she requests, (3) his/her moral and ethical qualifications for staff membership, and (4) his/her ability to work with others as necessary to ensure quality patient care, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

d. releases from any liability the hospital and all representatives of the hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials, and releases from any liability all individuals and organizations who provide information concerning the applicant to the hospital in good faith and without malice;

e. consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant’s professional or ethical standing that the hospital or Medical Staff may have, and releases the Medical Staff and hospital from liability for so doing in good faith and without malice, to the fullest extent permitted by law;

f. if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;

g. pledges to provide for continuous quality care for patients;

h. pledges to maintain an ethical practice;

i. pledges to abide by the Medical Staff Bylaws, Rules & Regulations, and credentialing and hospital clinical policies as shall be in force from time to time during any period of Medical Staff membership; and

j. agrees to provide to the Medical Staff new and updated information regarding all questions on the application form.

k. pledges to observe all medical staff policies, and Rules & Regulations concerning privacy and confidentiality of patients’, persons, records and hospital affairs.

l. Understands that any significant falsifications, misstatements in, or omissions from, the medical staff application may deem the application null and void and ineligible for processing.

4.4.4 The terms “hospital” and “all representatives of the hospital and the Medical Staff” as used in this Article IV are intended to include the Board, the Chief Executive Officer, the Chief Operating Officer and their authorized representatives, and all members of the Medical Staff who participate in collecting and/or evaluating the applicant’s credentials and/or acting upon the application. The application form shall contain a statement that fully informs the applicant of the scope and extent of this authorization, and its release and consent provisions.

4.4.5 The completed application package is submitted by the Credentials Verification Office (CVO) to the Medical Staff Coordinator who reviews all irregularities (if applicable) and brings same to the attention of the Department Chair. The application package is taken to the appropriate Department Chair and once signed is transmitted to the Credentials Committee for review and
approval. No application package will be considered for acceptance by the Medical Staff Coordinator unless it is deemed complete by the CVO within one hundred eighty (180) days from the date the application form was submitted.

4.5 Appointment Process/Medical Staff Action

4.5.1 Department Action

After receipt of the application, each Department Chairman (or his/her designee) to which the application is submitted shall review the application and supporting documentation. The Department Chairman may elect to interview the applicant and seek additional information. If the applicant requests an interview, the chair shall grant the request. The Department Chairman shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The department chair may also request that the Credentials Committee defer action on the application. Whenever a department chair is not reasonably available to take any action or make any decision called for by these Bylaws, the Vice-Chairman of the applicable department shall be responsible for such action or decision. If the Vice-Chairman is also not reasonably available, then the immediate past department chair shall be responsible for such action or decision. If the immediate past Department Chairman is also not reasonably available, then the applicable Credentials Committee representative shall be responsible for such action or decision.

4.5.2 Credentials Committee Action

The Credentials Committee shall review the application, evaluate, and verify the supporting documentation, the department’s report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. If the applicant requests an interview, the Committee shall grant the request. As soon as practicable, the Credentials Committee shall transmit to the campus Medical Executive Committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also recommend that the campus Medical Executive Committee defer action on the application. In the absence of an active Credentials Committee, the campus Medical Executive Committee shall serve as the Credentials Committee.

4.5.3 Campus Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the campus Medical Executive Committee shall consider the report and any other relevant information. The campus Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The campus Medical Executive Committee shall forward to the hospital CEO for prompt transmittal to the Board, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The campus Medical Executive Committee may also defer action on the application or refer the application to the Physician Council as set forth in Section 11.3 if there are issues or questions concerning the application not specifically covered in these Bylaws. The reasons for each recommendation shall be stated.

4.5.4 Physician Council Action – PBH doesn’t have one

After receiving the referral of an application or question from the campus Medical Executive Committee, a meeting of the Physician Council will be called as soon as practical. The Physician Council shall consider the application in question and any other relevant information. The Physician Council may request additional information, return the matter to the campus Medical Executive Committee for further investigation, and/or elect to interview the applicant. The Physician Council shall forward to the referring campus Medical Executive Committee, a written report and recommendation as to Medical Staff appointment, and, if appointment is recommended, as to hospital specific membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The
Physician Council may also defer action on the application. The reasons for each recommendation shall be stated.

4.5.5 **Effect of Campus Medical Executive Committee Action**

When the recommendation of a campus Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board. When a final recommendation of a campus Medical Executive Committee is adverse to the applicant, the Board and the applicant shall be promptly informed by written notice from the hospital CEO or his/her designee. The applicant shall then be entitled to the procedural rights as provided in Article VII.

4.6 **Board Action on the Application**

4.6.1 The Board may accept the recommendation of the campus Medical Executive Committee or may refer the matter to the campus Medical Executive Committee or the Physician Council for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to Board action on the application:

a. If a campus Medical Executive Committee issues a favorable recommendation, the Board shall affirm the recommendation of the campus Medical Executive Committee, if the campus Medical Executive Committee’s decision is supported by substantial evidence. If the Board concurs in that recommendation, the decision of the Board shall be deemed final action. If the tentative final action of the Board is unfavorable, the hospital CEO or his/her designee shall give the applicant written notice of the tentative adverse recommendation, and the applicant shall be entitled to the procedural rights set forth in Article VII. If the applicant waives his or her procedural rights, the decision of the Board of shall be deemed final action.

b. In the event the recommendation of a campus Medical Executive Committee, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article VII shall apply. If the applicant waives his or her procedural rights, the recommendations of the campus Medical Executive Committee shall be forwarded to the Board for final action, which shall affirm the recommendation of the campus Medical Executive Committee if the campus Medical Executive Committee’s decision is supported by substantial evidence. If the applicant requests a hearing following an adverse campus Medical Executive Committee recommendation pursuant to this Section 4.6.1b., or an adverse Board tentative final action pursuant to Section 4.6.1a., the Board shall take final action only after the applicant has exhausted his or her procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the Board shall make a final decision and shall affirm the decision reached through those procedures, if such decision is supported by substantial evidence, following a fair procedure. The Board’s final decision shall be in writing and shall specify the reasons for the action taken.

4.6.2 Notice of the final decision of the Baptist Health Board shall be given to the Medical Staff Coordinator (MSC) at the respective campus (es) by the recording secretary responsible for maintaining the minutes of the Board. A notice to appoint or reappoint is generated by the MSC or other campus designee and shall include, if applicable: (a) the hospital specific staff category to which the applicant is appointed; (b) the department to which that practitioner is assigned; (c) the clinical privileges granted; and (d) any special conditions attached to the appointment.

4.7 **Reapplication After Adverse Appointment Decision**

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.8 **Timely Processing of Applications**

Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

4.8.1 Evaluation, review, and verification of application and all supporting documents: thirty (30) days from receipt of all necessary documentation.
4.8.2 Review and recommendation by department(s): thirty (30) days after receipt of all necessary documentation from the Medical Staff office.

4.8.3 Review and recommendation by Credentials Committee: thirty (30) days after receipt of all necessary documentation from the department(s).

4.8.4 Review and recommendation by campus Medical Executive Committee: thirty (30) days after receipt of all necessary documentation from the Credentials Committee.

4.8.5 Review and recommendation, if referred by the campus Medical Executive Committee to the Physician Council: sixty (60) days after receipt of all necessary documentation from the campus Medical Executive Committee.

4.8.6 Final action: review and recommendation by the Board ninety (90) days after receipt of all necessary documentation by the Board and seven (7) days after conclusion of the hearings.

4.9 Reappointment and Requests for Modifications of Staff Status or Privileges

4.9.1 At least three (3) months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form as recommended by the Physician Council and approved by both Medical Executive Committees, shall be mailed or delivered to the member. If an application for reappointment is not received at least sixty (60) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least forty-five (45) days prior to the expiration date, each Medical Staff member shall submit to the Medical Staff coordinator the completed application form for renewal of appointment to the staff for the coming two-year period, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.4.2, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth in Section 4.4.4. A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time to the Credentials Verification Office.

4.9.2 The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.4.3.

4.9.3 When a staff member submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.4 through 4.6 and other applicable provisions of these Bylaws.

4.9.4 Failure without good cause to file timely a completed application for reappointment shall result in the automatic termination of the member’s admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment. If the member fails to submit a completed application for reappointment, the member shall be deemed to have voluntarily resigned his/her medical staff membership and clinical privileges. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.9.5 Application for staff category upgrade: At reappointment and/or upon having met established criteria pursuant to Section 8.3 of these Bylaws, members may submit a written request for a higher category of membership. The National Practitioner Data Bank and license verification shall be queried on those physicians requesting category upgrade.

4.10 Leave of Absence

4.10.1 At the discretion of the campus Medical Executive Committee, a member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee. The period of leave shall be that as approved by the campus Medical Executive Committee in its discretion, but shall be for no less than one (1) month, but no longer than 12 months. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation for reappointment and to pay dues, if any, shall continue, unless waived by the campus Medical Executive Committee.

4.10.2 If a member takes a leave of absence from one Baptist Health facility, they must take it from all Baptist Health facilities. Under unusual circumstances, a member may request a leave of absence at only one facility, if approved by the campus Medical Executive Committee of all facilities.
4.10.3 At least thirty (30) days prior to termination of the leave of absence, or at any earlier time, the member may request reinstatement of privileges by submitting a written request to that effect to the BH-CVO. The member shall also submit an explanation and summary of relevant activities during the leave. The BH-CVO will validate the relevant activities and the request shall be processed in accordance with the procedures set forth in Sections 4.1 through 4.8 (except for Section 4.3 – Application Process). If the leave of absence is determined to be related to impairment and participation in a rehabilitation/treatment program, the requirements and processes of the Physician Well Being policies as set forth in the campus Rules & Regulations shall also be applied to have the member’s privileges reinstated.

4.10.4 Application for temporary privileges for non-impaired physicians may be granted sooner on a case by case basis.

4.10.5 Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE V: CLINICAL PRIVILEGES

5.1 Clinical Privileges

5.1.1 Except as otherwise provided in these Bylaws, a member providing clinical services at a Baptist Health facility shall be entitled to exercise only those clinical privileges specifically requested and granted him or her by the Board, except as provided in Sections 5.2 and 5.3. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state (and consistent with any restrictions thereon), and shall be subject to the Rules & Regulations of the clinical department and the authority of the department chair and the Medical Staff. Medical Staff privileges may be granted, continued, modified or terminated by the Board only upon recommendation of the Medical Staff, and only following the procedures outlined in the Medical Staff Bylaws. The termination, granting, continuation or modification of Medical Staff privileges based on economic criteria unrelated to clinical qualifications, professional responsibilities or quality of care is prohibited, with the exception of statutory, regulatory, or judicial requirements, or other exception which may be defined in the Medical Staff Bylaws. When privileges are granted it also includes the right to exercise those privileges.

5.1.2 Every initial application for Medical Staff appointment must include a delineation of the specific privileges requested by the applicant. The evaluation of such requests shall be based upon the applicant’s education, training, experience, demonstrated current professional competence and judgment, references and other relevant information, including an appraisal and recommendation by the appropriate department chair. Privilege determinations may be based on pertinent clinical performance information obtained from other sources, including other institutions and health care settings where a member exercises clinical privileges. The applicant has the burden of establishing his/her qualifications and current competency to perform each clinical privilege requested.

5.1.3 An evaluation and review of each physician’s clinical privileges will be undertaken as a part of the reappointment process, and will be based on direct observation of clinical performance, a review of patient records, and a review of the records of Medical Staff proceedings, including quality improvement programs.

5.1.4 All requests by a practitioner for changes in clinical privileges must be supported by documented training and experience and such other criteria as may be required by the applicable department and/or the Credentials Committee.

5.1.5 Privileges granted to each oral surgeon shall be based on his/her training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each oral surgeon may perform shall be specifically delineated and granted in the same manner as other surgical privileges. Surgical procedures performed by oral surgeons shall be under the overall supervision of the chair of the surgery department. All oral surgery patients shall receive the same medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff must be identified to be responsible for the preparation of a history and
physical on the patient, and for the management of any medical problem that may be present at
the time of admission or that may arise during hospitalization.

5.1.6 Initial and additional clinical privileges may be granted by the Board following review and
approval by the credentials and campus Medical Executive Committees.

5.2 Temporary Privileges

5.2.1 After (1) receipt of a completed application form and all the documents supporting such
application, as given in 4.4, and after the application has been given favorable action by the
Chair of the Department or his/her designee, to which the applicant would be assigned, and after
favorable action by the Credentials Committee and the campus Medical Executive Committee,
the hospital CEO (or his/her designee) may grant temporary privileges to the applicant until such
time as the Board can consider the application, provided applicant has no current or previously
successful challenge to licensure or registration; has not been subject to involuntary termination
of medical staff membership at another facility; has not been subject to involuntary limitation,
reduction, denial or loss of clinical privileges; and the hospital has not determined that there has
been either an unusual pattern of, or an excessive number of, professional liability actions
resulting in a final judgment against the applicant.

5.2.2 The period of temporary privileges so granted in 5.2.1 shall not exceed 120 days. If the Board
decides to grant staff membership and regular privileges, the temporary privileges shall
terminate and the applicant will be notified by the hospital CEO of the Board’s decision. The
member is expected to conclude any medical care and medical records at the respective
hospital campus.

5.2.3 A practitioner who is not applying for Medical Staff membership may nevertheless request
temporary clinical privileges to care for a specific patient. The practitioner making such a request
must provide all information required by the hospital, including proof of (1) his/her license to
practice medicine in Alabama, (2) valid federal and state narcotics licenses, and (3) the required
professional liability insurance coverage. The hospital CEO (or his/her designee) may grant such
temporary privileges with the concurrence of the campus Chief of Staff (or his/her designee – the
clinical Department Chair). Such temporary privileges shall terminate upon the discharge of the
specific patient for which such privileges are granted.

5.2.4 Locum Tenens and Administrative Temporary Privileges: Jointly, the hospital CEO (or his/her
designee) and the Chief of Staff (or his/her designee) may permit a physician to serve as a
locum tenens for another member of the Medical Staff and to attend such member’s patients
without membership on the Medical Staff for a period not to exceed a total of ninety (90) days.
Jointly, the hospital CEO (or his/her designee) and the Chief of Staff (or his/her designee) may
grant a physician administrative temporary privileges for a period not to exceed sixty (60) days.
The physician is required to submit (1) a completed application form, (2) a delineation of clinical
privileges form for each respective campus, (3) a copy of his/her Alabama license and his/her
federal DEA certificate and Alabama controlled substance certificate, (4) proof of adequate
malpractice insurance, and (5) a written request from the Medical Staff member, stating the
specific dates/period that the locum tenens physician will be covering for him/her or the reason
for the urgent need for administrative temporary privileges. This application must be approved
by the campus Chief of Staff (or his/her designee – the clinical Department Chair) and by the
hospital CEO (or his/her designee), before the physician will be allowed to attend patients at the
hospital.

5.2.5 Special conditions of supervision and/or reporting may be imposed by the clinical department
chair on any practitioner granted temporary privileges. Temporary privileges will be immediately
terminated by the hospital CEO (or his/her designee) upon notice of any failure by the
practitioner to comply with any such special conditions.

5.2.6 The hospital CEO (or his/her designee) may at any time, upon recommendation of the campus
Chief of Staff or clinical department chair, terminate a practitioner’s temporary privileges. The
appropriate clinical department chair or the campus Chief of Staff shall assign an appropriate
member of the Medical Staff to assume responsibility for the care of the affected practitioner’s
patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be
considered, where reasonably feasible, in the selection of a substitute practitioner.

5.2.7 No practitioner will be entitled to the procedural rights afforded by Article VII of these Bylaws
because of his/her inability to obtain temporary privileges, or because of any termination or
suspension of temporary privileges, unless such inability, termination or suspension is based
upon the professional competence or professional conduct of the practitioner.
5.3 Emergency Privileges

5.3.1 In an emergency situation, any physician or oral surgeon member of the Medical Staff, to the degree permitted by his/her license, is permitted to do everything reasonably possible to save the life of a patient or to save the patient from serious harm, using every necessary facility of the hospital. The member shall make every reasonable effort to communicate promptly with the appropriate department chair regarding the need for emergency care and assistance by those with appropriate clinical privileges.

5.3.2 In an emergency situation, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

5.3.3 When the emergency situation no longer exists, the treating physician or oral surgeon may request temporary privileges to continue to treat the patient. Should that request be denied or if the physician does not request such privileges, the care of the patient shall be reassigned to a member with appropriate clinical privileges by the campus Chief of Staff or the appropriate clinical department chair, subject to approval by the patient.

5.3.4 For the purpose of this Section 5.3, an "emergency" is defined as a condition in which a patient is threatened with serious or permanent harm, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger.

5.4 Modification of Clinical Privileges or Department Assignment

5.4.1 On its own, upon recommendation of the Credentials Committee, or pursuant to a request under Section 4.9.1, the campus Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The campus Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to special conditions of supervision and/or reporting.

5.5 Medical Records

5.5.1 A medical history and physical examination must be completed for each patient no more than 30 days before admission or 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services. When using an H&P written prior to admission, the physician must document on the H&P or the Progress Notes an updated examination of the patient including any changes in the patient's condition. This "update" must be completed and documented within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services. The appropriate examination noting the patient’s current status is required regardless of whether any changes have occurred in patient’s condition since the H&P was originally composed. This update should be dated, timed and signed. The H&P must be performed by a physician, oral/maxillofacial surgeon or other qualified licensed individual with granted privileges in accordance with state law and hospital policy.

ARTICLE VI: CORRECTIVE ACTION

6.1 Routine Corrective Procedure

For the purposes of these Bylaws, any corrective action must be taken (1) in the reasonable belief that the action is in the furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures as described in these Bylaws are afforded to the member or after such other procedures as are fair to the member under the circumstances; (4) in the reasonable belief that the action was warranted by the facts known after a reasonable effort to obtain the facts; and (5) after complying with the foregoing requirements of this Article. The provisions of this article apply only to the physician and oral surgery members of the Medical Staff, as defined in Article 3.1. Limited Licensed Professionals, Allied Health Professionals and Special Limited Staff have a right to a fair hearing before a committee appointed by the campus Medical Executive Committee and an appeal before the campus Medical Executive Committee in the event of any adverse decision by the committee. The appeal decision by the campus Medical Executive Committee is final.

6.1.1 When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care
within the hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws and Rules & Regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by any officer of the Medical Staff, by the chair of any standing committee, or by any department chair. Such a review will be initiated following receipt of a written statement to the CEO or hospital CEO, campus Medical Executive Committee, campus Chief of Staff or a department chair, stating the specific activities or conduct which merit a review.

6.1.2 The campus chief of staff, and the appropriate department chair, and the hospital CEO or the designees thereof, shall conduct an initial review of the alleged problem/situation. The purpose of this review is to determine the validity of the complaint and the scope of the problem; such review shall not constitute a “hearing” as that term is used in Article VII, nor shall procedural rules with respect to hearings or appeals apply. The member involved shall be notified that a review is being conducted; the practitioner in question will be notified and given an opportunity to respond. If the initial review shows the complaint to be unwarranted or without merit, then the written statement shall be destroyed and no further action taken.

6.1.3 If the problem/situation is determined to be minor in nature, then the practitioner may be counseled by either the department chair or by a committee of peers appointed by the department chair. If the practitioner is counseled, then the department chair or a member of the committee shall note the date of the meeting with the practitioner and the substance of the discussions, and any action taken/suggested. Such meeting shall not constitute a “hearing” as that term is used in Section 6.1.5 of this Article, nor shall procedural rules with respect to hearings or appeals pursuant to Article VII apply. The report of this meeting, and any written response to same by the practitioner, shall become a part of the practitioner’s quality improvement file.

6.1.4 If the problem/situation is determined to be or to have been serious, or potentially serious if not corrected, the Department Chairman shall appoint an ad hoc investigating committee of three practitioners to investigate the problem. No more than one of the investigating practitioners may be of the same specialty and none shall be in direct economic competition with the practitioner being investigated.

6.1.5 Following appointment of the ad hoc investigating committee, the Department Chairman will, within 48 hours, advise the practitioner in question of the specific nature of the problem under review and that a date will be set for the review of the problem. At that time the practitioner shall be invited to explain the circumstances surrounding the problem. That meeting shall be held as soon as practical but no sooner than thirty (30) days after notice to the physician unless an earlier date is requested by the physician. The physician may be accompanied at the hearing by another member of the Medical Staff or by his/her attorney; however, neither may directly participate in the hearing. Other persons who have knowledge bearing on the problem under review will be invited to share their information with the investigating committee. This review of the problem shall not constitute a hearing and none of the procedural rules provided in these Bylaws shall apply thereto. Minutes of the proceedings of the investigating committee shall be recorded. The minutes of the investigating committee’s review of the problem along with the committee’s recommendation(s) shall be forwarded to the campus Medical Executive Committee of the Medical Staff for their review and action no later than their next regularly scheduled meeting.

6.1.6 The decision of the campus Medical Executive Committee may be to accept, reject or to modify the recommendations of the investigating committee, to issue a warning, to issue a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges or to recommend suspension or revocation of the practitioner’s Medical Staff membership.

6.1.7 Any recommendation by the campus Medical Executive Committee to reduce, suspend or revoke Medical Staff privileges or to suspend or revoke Medical Staff membership shall entitle the affected practitioner to the procedural rights provided in Article VII of these Bylaws.

6.1.8 If at any point in the investigative procedure, the practitioner’s actions warrant precautionary summary suspension, this action may be taken as provided in paragraph 6.2.1.

6.1.9 All recommendations and actions taken shall be made available to the appropriate Medical Staff bodies and to the Board for review when the practitioner is considered for reappointment to the Medical Staff.

6.1.10 If the campus Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board may direct the campus Medical Executive
Committee to initiate investigation or disciplinary action, but only after consultation with the
campus Medical Executive Committee. If the campus Medical Executive Committee fails to
take action in response to that Board direction, the Board may initiate corrective action, but this
corrective action must comply with the Medical Staff Bylaws.

6.1.11 If any report is to be made to the Data Bank regarding any adverse action taken against a
practitioner, the practitioner shall be given fourteen (14) days’ notice of same being submitted.

6.2 Precautionary Summary Suspension of Clinical Privileges

6.2.1 Whenever a member’s conduct appears to require that immediate action be taken to protect
the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of
significant impairment of the life, health, safety of any patient, prospective patient, or other
person, either the campus Chief of Staff, the campus Medical Executive Committee, or the
appropriate department chair (or his/her designee), or the hospital Administrator or his/her
designee, in concert with another physician, has the authority to impose a precautionary
summary suspension on a Medical Staff member of all or any portion of the clinical privileges
of such Medical Staff member. Such a precautionary summary suspension shall be deemed
an interim precautionary action and not a professional review action. It shall not imply any
final finding of responsibility for the situation, which caused the suspension. The
precautionary summary suspension or restriction may be limited in duration and shall remain
in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise
indicated by the terms of the precautionary summary suspension or restriction, the member’s
patients shall be promptly assigned to another member by the department chair or by the
campus Chief of Staff, considering where feasible, the wishes of the patient in the choice of
the substitute member.

6.2.2 Within one working day of imposition of a precautionary summary suspension, the affected
Medical Staff member shall be provided with written notice of such suspension. The initial
written notice shall include a statement of facts demonstrating that the suspension was
necessary because failure to suspend or restrict the practitioner’s privileges summarily could
reasonably result in an imminent danger to the health of an individual. The statement of facts
provided in this initial notice shall also include a summary of one or more particular incidents
giving rise to the assessment of imminent danger. This initial notice shall not substitute for,
but is in addition to, the notice required under Section 7.1.2.

6.2.3 A precautionary summary suspension becomes effective immediately upon imposition.
Immediately following the imposition of a “precautionary summary suspension” the party
imposing the suspension shall notify the appropriate Department Chairman, the campus Chief
of Staff, the hospital CEO, and/or the chairman of the Board. This group, or such of their
number as shall be available and necessary, shall initiate an immediate investigation into the
matter(s), which precipitated the precautionary summary suspension. Their review shall be
completed within a reasonable time period not to exceed thirty (30) days.

6.2.4 Within 72 hours after such precautionary summary restriction or suspension has been
imposed, a meeting of the campus Medical Executive Committee (or a subcommittee
appointed by the campus Chief of Staff) shall be convened to review and consider the action.
Upon request of the member or the committee, the member shall attend and make a
statement concerning the issues under investigation, on such terms and conditions as the
campus Medical Executive Committee may impose, although in no event shall any meeting of
the campus Medical Executive Committee, with or without the member, constitute a “hearing”
within the meaning of Article VII, nor shall any procedural rules apply. The campus Medical
Executive Committee may modify, continue, or terminate the precautionary summary
restriction or suspension, but in any event it shall furnish the member with notice of its
decision within 72 hours of the meeting.

6.2.5 The imposition of a precautionary summary suspension does not in any of itself entitle the
physician to request a hearing or appeal. However, should the precautionary summary
suspension investigation result in a recommendation "adverse" to the physician, then the
physician shall be entitled to a hearing and appeal as outlined in Article VII. In addition, the
affected practitioner shall have the following rights:

a. Any affected practitioner shall have the right to challenge imposition of the precautionary
summary suspension, particularly on the issue of whether or not the facts stated in the
notice present a reasonable possibility of “imminent danger” to an individual. Initially, the
practitioner may present this challenge to the campus Medical Executive Committee at
the meeting held within one week of imposition of the suspension. If the campus Medical Executive Committee’s decision is to continue the summary suspension, then any hearing properly requested by the practitioner shall be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of precautionary summary suspension. Along with any other appropriate requests for rulings, the affected practitioner may request that the hearing panel stay the precautionary summary suspension, pending the final outcome of the hearing and any appeal.

b. At the conclusion of the procedural portion of the hearing, the hearing panel, shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to restrict or impose a precautionary summary suspension could reasonably result in “imminent danger” to an individual. Such written opinion shall be transmitted to both the affected practitioner and the campus Medical Executive Committee within two working days of the date of the procedural hearing.

c. If the hearing panel determines that the facts stated in the notice required by Section 6.2.2 do not support a reasonable determination that failure to restrict or suspend the practitioner’s privileges could result in imminent danger, the precautionary summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

d. If the hearing panel determines that the facts stated in the notice required by Section 6.2.2 support a reasonable determination that a precautionary summary suspension was necessary to avoid imminent danger to an individual, the precautionary summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

6.2.6 If the campus Chief of Staff, members of the campus Medical Executive Committee and the Department Chairman (or his/her designee) in which the member holds privileges are not available to impose a precautionary summary suspension, the Board (or its designee) may impose a precautionary summary suspension if a failure to do so is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the Board (or its designee) made reasonable attempts to contact the campus Chief of Staff, members of the campus Medical Executive Committee and the appropriate Department Chairman (or his/her designee) before the suspension. Such a suspension is subject to ratification by the campus Medical Executive Committee. If the campus Medical Executive Committee does not ratify such a precautionary summary suspension within two (2) working days, excluding weekends and holidays, the precautionary summary suspension shall terminate automatically. If the campus Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.2 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the campus Medical Executive Committee for purposes of compliance with notice and hearing requirements.

6.3 Automatic Suspension
In the following instances, the member’s privileges may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

6.3.1 A temporary interruption of all Medical Staff privileges will automatically be imposed for delinquent medical records. The procedure for determining delinquent medical records is defined in the Rules & Regulations of the Medical Staff along with the process. Members whose privileges have been temporarily interrupted or suspended (based upon exceeding a defined number of temporary interruptions) for delinquent records may admit patients only in life-threatening situations.

6.3.2 Any Medical Staff member whose license to practice medicine or oral surgery in the State of Alabama is revoked or suspended is automatically and immediately suspended from the Medical Staff as of the date such action is effective.

6.3.3 Whenever a member’s license or other legal credential authorizing practice in this state is limited or restricted, or whenever a member is placed on probation, by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation, restriction or probation shall be automatically
limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

6.3.4 A Medical Staff member whose federal or state narcotic certification is revoked or suspended is immediately and automatically divested of his/her privilege to prescribe medications covered by such certification and his/her clinical privileges may be suspended.

6.3.5 Failure without good cause as determined by the campus Medical Executive Committee, to pay dues or assessments, as required shall be ground for automatic suspension of a member’s clinical privileges, and if within three months after written warnings of the delinquency the member does not pay the required dues or assessments, the member’s membership shall be automatically terminated.

6.3.6 Failure to maintain professional liability insurance shall be grounds for automatic suspension of clinical privileges. The affected member’s clinical privileges shall be immediately reinstated upon receipt of current liability insurance. If within 30 days after written notification of the suspension the member does not provide evidence of required professional liability insurance, the member’s membership shall be automatically terminated.

6.3.7 Upon conviction of a felony or a crime involving moral turpitude or permanent suspension from participation in the Medicare or Medicaid program by a government agency, a practitioner may be immediately suspended from Medical Staff membership at the discretion of the campus Medical Executive Committee.

6.3.8 At the time of suspension, a certified mail, return receipt letter is sent to the affected practitioner. Notification is also sent to various internal departments requesting immediate suspension of all access to the hospital including scheduling of cases, use of badge as well as access to the IT applications. The Credentials Verification Office oversees compliance. Failure to respond as indicated in each of the above reference line items under Section 6.3 will result in automatic termination.

6.3.9 Following an automatic suspension as referenced in this article, except for Section 6.3.1 (delinquent medical records), the campus Medical Executive Committee will review and consider the facts under which the practitioner was suspended within thirty (30) days of the action. The committee may then take such further corrective action as is deemed appropriate in light of the facts presented.

6.4 Disposition of Corrective Action Reports
All corrective action reports shall be made a part of the physician’s quality assurance file and reviewed every two (2) years at the time of reappointment. Reports arising under Section 6.1.3 shall be purged from the quality assurance file after four (4) years, if there has been no repeat of the same, or a related problem within that time period. Timely notice and opportunity to provide written rebuttal for any adverse entry into the physician’s quality assurance file shall be granted to the physician. The written rebuttal will become a part of the physician’s quality assurance file.

ARTICLE VII: HEARING AND APPELLATE REVIEW PROCEDURES

7.1 Request for a Hearing
7.1.1 Grounds for a Hearing: The basis for a hearing shall consist of a final action or a recommendation of final action by the Board, or a recommendation by the campus Medical Executive Committee (except a recommendation under Section 6.1.7), which is adverse to the applicant or member and which constitutes or which if adopted would constitute:
(1) Denial of requested Medical Staff membership or privileges.
(2) Denial of Medical Staff reappointment;
(3) Suspension of or expulsion from Medical Staff membership; or
(4) Reduction, suspension or termination of privileges.

7.1.2 Notice of Decision: The notice shall be in substantially the form, which is made a part of these Bylaws as Exhibit 1 to this Article VII and shall contain the information set forth therein.

7.1.3 Notice of Hearing: The Notice of Decision form (Exhibit 1 to this Article VII) shall provide a space for the affected Medical Staff member to request a hearing in writing. This request must be returned to the hospital CEO, by certified mail, return receipt requested within thirty (30) days of receipt of the notice by the practitioner.

7.1.4 Waiver of a Hearing: Failure to request a hearing as set forth herein constitutes a waiver of the right to a hearing. When the waived hearing relates to an adverse recommendation of the campus Medical Executive Committee or final action or a recommendation of final action by the
Board, the adverse recommendation shall thereupon become and remain effective against the physician or oral surgeon pending the Board’s decision on the matter. When the waived appeal hearing relates to an adverse decision by the Board, the same shall thereupon become and remain effective against the physician or oral surgeon in the same manner as the final decision of the Board provided for in these Bylaws. In either of such events, the hospital CEO or his/her designee shall promptly notify the affected physician or oral surgeon of his/her status by certified mail, return receipt requested.

7.1.5 Hearing Schedule: Within seven (7) days after receipt of a request for a hearing from a physician or oral surgeon entitled to the same, the campus Medical Executive Committee or the Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the hospital CEO, notify the physician or oral surgeon of the time, place and date of the scheduled hearing by certified mail, return receipt requested. The hearing date shall not be less than thirty (30) days from the date of receipt of the physician’s or oral surgeon’s request for a hearing, unless the physician or oral surgeon requests an earlier date. If the physician or oral surgeon feels that the hearing date will not allow him/her a reasonable time in which to prepare his/her defense, he/she may request an extension of time in writing, provided that in no event shall the hearing date be more than sixty (60) days from receipt of the request for a hearing unless so set by agreement of all parties. The notice of a hearing shall set forth the time, date and place of the hearing and shall additionally advise the physician or oral surgeon that an extension will be granted upon written request if the affected practitioner has inadequate time to prepare his/her defense. This notice shall also advise the affected Medical Staff member that in no event shall the extension be granted for a period of more than sixty (60) days after receipt of a request for a hearing, unless so set by agreement of all parties.

7.1.6 Composition of the Hearing Committee
a. When the hearing relates to an adverse recommendation of a campus Medical Executive Committee, such hearing shall be conducted by an ad hoc hearing committee of no fewer than five (5) members of the active Medical Staff of the campus involved, appointed by the campus Chief of Staff in consultation with the appropriate Department Chairman. One of the members so appointed shall be designated as chairperson. No Medical Staff member who has actively participated in the investigation and consideration of the adverse recommendation shall be appointed a member of this hearing committee. The committee shall include an individual practicing the same specialty, not in direct economic competition with the affected practitioner. If the direct economic competitive portion of the above criteria cannot be met with active staff members, a member of the courtesy or provisional staff or a non-staff member may be appointed as a nonvoting advisor.

b. When the hearing relates to an adverse decision of the Board that is contrary to the recommendation of the Credentials Committee or a campus Medical Executive Committee, the Board shall appoint a hearing committee of no fewer than five (5) members from the active Medical Staff of the campus involved to conduct the hearing and shall designate one of the members as chairperson. No staff member who has actively participated in the investigation and consideration of the adverse recommendation shall be appointed a member of this hearing committee. The committee shall include an individual practicing the same specialty, not in direct economic competition with the affected practitioner. If the direct economic competitive portion of the above criteria cannot be met with active staff members, a member of the courtesy or provisional staff or a non-staff member may be appointed as a non-voting advisor.

7.1.7 Parties: The parties to this hearing shall be the applicant or member and one member from the campus Medical Executive Committee, if their action prompted the hearing or one member or designated representative of the Board if its action prompted the hearing.

7.1.8 Right to Materials Prior to an Appeal Hearing: When the notice of a hearing as provided in these Bylaws refers to specific cases, the practitioner requesting the hearing shall have the right to a copy of those medical records in order to prepare for the hearing. The affected practitioner shall also have the right to copies of any other documents, which may form the basis of the adverse recommendation given in the notice.

7.1.9 Exchange of Witnesses: The ad hoc appeal hearing committee shall order both parties to exchange the names of witnesses prior to the hearing. However, it is not contemplated by this exchange that any formal statements prior to the hearing will be allowed by the ad hoc hearing committee for the purpose of using those statements to cross-examine witnesses. The
purpose of the order to exchange witnesses is merely to afford all parties disclosure of the expected witnesses at the hearing.

7.2 Hearing Procedure

7.2.1 Ad Hoc Hearing Committee: Within the guidelines provided in these Bylaws, the ad hoc hearing committee shall establish the procedure for the conduct of the hearing; shall make preliminary rulings and decisions; and may grant postponements and extensions of time.

7.2.2 Failure to Appear: Failure without good cause of the practitioner requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved which shall become final and effective immediately. Failure without good cause of the representative of the campus Medical Executive Committee or the Board as the case may be to appear and proceed at such a hearing, shall be deemed to constitute voluntary rejection of the recommendations or actions involved.

7.2.3 Representation: The hearing provided for in Section 7.1 et al is for the purpose of intra-professional resolution of matters relating to professional competency. The Medical Staff member requesting the hearing may elect to obtain legal counsel for purpose of preparing for and consultation during the hearing. In the event the Medical Staff member elects to retain legal counsel, notice of this election must be given to the ad hoc hearing committee which in turn should advise the representative of campus Medical Executive Committee or the Board as the case may be. The campus Medical Executive Committee, the Board or their appointed representative shall have the right to retain legal counsel. The practitioner requesting the hearing shall also be entitled to be accompanied and represented at the hearing by a member of the Medical Staff. The representative of the campus Medical Executive Committee or the Board shall also have the right to be accompanied and represented by a physician or surgeon (or in the case of an oral surgeon, by an oral surgeon) who, is a member in good standing of the Medical Staff.

7.2.4 Ad Hoc Review Committee Attendance at Hearing: There shall be at least a majority of the members of the ad hoc hearing committee present when any session of the hearing takes place. No member may vote who did not attend all sessions of the hearing.

7.2.5 Presiding Officer: The presiding officer at the hearing shall be the chairman of the ad hoc hearing committee unless a hearing officer is appointed, in which case the hearing officer will be presiding officer. The presiding officer shall conduct the hearing so as to provide all participants with a reasonable opportunity to be heard, to present all oral and documentary evidence, and shall maintain decorum. He/she shall be entitled to determine the order of procedure during the hearing. He/she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions, which pertain to matters of law, and to admissibility of evidence.

7.2.6 The Hearing Officer: The ad hoc hearing committee may, in its discretion, appoint a hearing officer, who may be an attorney, to preside at the hearing. Such hearing officer may be legal counsel to the hospital, provided he/she acts within the line and scope of these Bylaws. He/she must not act as a prosecuting officer, as an advocate for the hospital, the Board, or the campus Medical Executive Committee. If requested by the ad hoc hearing committee, he/she may participate in that committee’s deliberations as a legal advisor to it, but shall not be entitled to vote.

7.2.7 Rights of Both Sides to Present Evidence: At the hearing, both sides shall be entitled to call and examine witnesses, to introduce exhibits and documentary evidence, to cross-examine witnesses on any matter relevant to the issues, to impeach any witness, and to rebut any evidence. If the applicant or member of the medical staff does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination, or he/she may be called and examined by the ad hoc hearing committee.

7.2.8 Admissibility of Evidence: The hearing shall not be limited by rules of law relating to the examination of witnesses or presentation of evidence. Each party shall have the right to submit a memorandum of points and authorities, and the ad hoc hearing committee may request such a memorandum to be filed following the close of the hearing. The ad hoc hearing committee may interrogate the witnesses or call additional witnesses whom it deems appropriate. The evidence considered at this hearing shall be evidence only relevant to the charges made in the original notice. If the charges made in the original notice to the affected practitioner include a sample of cases, the cases used to judge the affected physician or practitioner shall be fairly selected and the method of selection shall be designed to offer a fair
sample of the affected Medical Staff member’s medical cases. Any evidence admitted should be reliable and trustworthy and shall not be speculative or conjectural.

7.2.9 **Official Notice:** The presiding officer shall have the discretion to take official notice of any matters either technical or scientific, related to the issues under consideration, where appropriate. Participants in the hearing shall be informed of the matters to be officially noticed and they shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the notice of matters by evidence.

7.2.10 **Record of the Hearing:** The ad hoc hearing committee shall maintain a record of the hearing by one of the following methods; a court reporter, a shorthand reporter present to make a record of the hearing, a tape recording or minutes of the proceedings. The ad hoc hearing committee may, but shall not be required to order that oral evidence be taken only on oath or affirmation administered by an individual designated by the committee who is entitled to notarize documents in the State of Alabama.

7.2.11 **Burden of Proof:** The burden of proof will be, in the initial hearing, on the campus Medical Executive Committee or the Board, as the case may be, which made the initial recommendation or entered the action giving rise to the Medical Staff member’s right to a hearing. The burden is to prove by clear and convincing evidence to the ad hoc hearing committee that the action recommended or taken is justified.

7.2.12 **Adjournment and Conclusion:** The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. However, in no event shall the hearing be reconvened after the time limit set forth in these Bylaws without the express written consent of the affected Medical Staff member. Such written consent shall not be withheld unreasonably or without good cause if in the discretion of the ad hoc hearing committee it is necessary to reconvene the hearing beyond the time limits set forth in these Bylaws.

7.3 **Decision of Ad Hoc Hearing Committee**

7.3.1 **Basis of Decision:** The decision of the ad hoc hearing committee shall be based on the evidence at the hearing.

7.3.2 **Time for Decision:** Within thirty (30) days after final adjournment of the hearing, the ad hoc hearing committee shall render a decision, which shall be accompanied by a written report to the campus Medical Executive Committee and the Board. The report shall contain a concise statement of the reasons justifying the decision made. At the same time, a copy of the report and decision shall be delivered to the person who requested the hearing, by certified mail return receipt requested. This report shall also advise the affected practitioner of his/her right to an appellate review as set forth in Section 4.

7.3.3 **Decision Final:** The decision of the ad hoc hearing committee shall be considered final, subject only to the right of appellate review as provided in Section 4 (Appellate Review Procedure).

7.3.4 **Effect of Decision:** The decision of the ad hoc hearing committee shall constitute the decision and recommendation of the Medical Staff.

7.4 **Appellate Review Procedure**

7.4.1 **Time for Appellate Review:** Within thirty (30) days after receipt of a decision of an ad hoc hearing committee (pursuant to Article VI or Section 7.1.6), the campus Medical Executive Committee or the affected practitioner may request an appellate review by the Board. Said request shall be delivered to the hospital CEO in writing either in person or by certified mail, return receipt requested. If such appellate review is not requested in such period of time, both sides shall be deemed to have accepted the decision and it shall thereupon become final and shall be effective immediately. The written request for appellate review shall include a brief statement as to the reason/basis for requesting an appellate review.

7.4.2 **Time, Place, and Notice:** In the event of a request for appellate review as set forth in the preceding subsection, the chairman of the Board or his designee shall, within ten (10) days after receipt of such notice of request for appellate review, schedule same. The appellate review shall be held no sooner than thirty (30) days after receipt of the notice of appeal, unless an earlier date is requested by the member/applicant. The appellate review shall be continued at the written request of the affected practitioner if the request is based upon the need to have additional time within which to prepare his appeal.
7.4.3 **Nature of Appellate Review:** The proceedings shall be in the nature of an appellate proceeding based upon the record of hearing before the ad hoc hearing committee. However, the appellate review committee may in its sole discretion, accept additional oral or written evidence related to the charges included in the original notice of an adverse recommendation or decision subject to the same rights of cross-examination or confrontation provided at the ad hoc hearing committee hearing. Each party shall have the right to present a written statement in support of his/her position on appeal, and in its sole discretion, the appellate review committee may allow each party or representative to personally appear and make oral argument. At the conclusion of oral argument, if allowed, the committee may thereupon at a time convenient to itself conduct deliberations outside of the presence of the parties and their representatives. The appellate review committee may affirm, modify or reverse the decision of the ad hoc hearing committee, or in its discretion, refer the matter for further review and recommendation.

7.4.4 **Access to Record and Report:** The affected medical staff member shall have access to the record of the hearing before the ad hoc hearing committee and all other materials, favorable and unfavorable, which were considered in making the adverse recommendation or decision against him/her. Such materials must be made available to the affected Medical Staff member at least ten (10) days before the appellate review is held. The affected Medical Staff member shall have the right to submit a written statement in his/her own behalf before the appellate review committee in which he/she shall outline those factual and procedural matters with which he/she disagrees, giving his/her reasons for such disagreement specifically. This written statement may cover all matters, which are relevant to the hearing procedure, both substantially and procedurally, and the affected Medical Staff member may obtain legal counsel to assist in the preparation of such written statement. A similar statement may be submitted by the representative of the Credentials Committee, the campus Medical Executive Committee or the Board, as appropriate. Copies of these written statements shall be made available to each party to the appellate review at least five (5) days prior to the appellate review. Extensions of time to submit these written statements so as to afford the right to exchange copies of these statements under these Bylaws may be granted within the discretion of the appellate review committee and shall be honored unless in the opinion of the committee the request is made only for the purpose of delay.

7.4.5 **Appellate Review Committee:** When an appellate review by the Board is requested, the chairman of the Board shall appoint an appellate review committee which shall be composed of not less than three (3) members of the Board who have not actively participated in the consideration of the matter involved at any previous level. Such appointment shall include designation of the committee chairman. Knowledge of the matter involved shall not preclude a member of the Board from serving as a member of the appellate review committee. The actions and decision of the appellate review committee shall have the same force and effect as would an action taken or decision made by the Board as a whole, and shall not be subject to further review or appeal.

7.4.6 **Function of Appellate Review Committee:** The appellate review committee shall act as an appellate body. It shall review the record of the ad hoc hearing committee and all materials submitted to the ad hoc hearing committee. It shall also consider the written statements submitted by the parties to the appeal. The committee should determine whether these materials support the adverse recommendation or decision against the affected Medical Staff member and should carefully determine whether the decision of the ad hoc hearing committee was justified. The appellate review committee should carefully review these materials to determine that the recommendation of the ad hoc hearing committee was not the product of prejudice, bias, or any other arbitrary or capricious reasoning.

7.4.7 **Oral Argument:** Oral argument, if allowed, shall be limited to a consideration of those matters properly considered by an appellate review committee. An affected practitioner, who is granted oral argument, must be present for the argument and his/her failure to appear shall operate as a waiver of his/her right to such oral argument. The affected practitioner shall be subject to questioning by the appellate review committee if he/she elects to request oral argument. The representative of the Credentials Committee, the campus Medical Executive Committee or the Board whichever is appropriate, shall also be afforded the opportunity to present oral argument if same is granted to the affected practitioner.

7.4.8 **New or Additional Evidence:** Any new or additional evidence not raised during the original hearing or contained in the transcript and record of the original ad hoc hearing committee shall
only be introduced and considered in the appellate review at the discretion of the appellate review committee and only after notice of such new or additional matters is given to all parties. The affected party shall have the right to prepare a defense, respond to any new or additional evidence, and shall have the right to request additional time within which to review and/or investigate the new or additional evidence offered.

7.4.9 **Right to Counsel:** The Medical Staff member shall have the right to legal counsel at an oral argument and the campus Medical Executive Committee, Credentials Committee or the Board may also be represented by counsel. Such right to counsel does not change the requirement that the Medical Staff practitioner be present at any requested oral argument and that he/she submit himself/herself to questioning by the appellate review committee on the matters made the subject of the appellate review. If the Medical Staff practitioner does not elect to have counsel at oral argument, then the campus Medical Executive Committee, Credentials Committee or the Board or their representative shall not be precluded from having counsel at the oral argument before the appellate review committee.

7.4.10 **Final Decision:** Within seven (7) days after the conclusion of the proceedings before the Appellate Review Committee, the committee shall render a final decision in writing and shall deliver or mail by registered mail, return receipt requested, copies thereof to the applicant or member of the Medical Staff and to the other party(s). The decision of the committee shall be final and shall be effective immediately upon completion of the appellate review proceedings and notification of the member or applicant.

7.4.11 **Right to One Hearing Only:** No applicant or member shall be entitled to more than one hearing or one appellate review on any single matter relating to application proceedings or corrective action.

7.4.12 The provisions of this Article apply only to the physicians and oral surgery members of the medical staff, as defined in Article 3.1.
NOTICE FORM

Dear Doctor:

The Campus Medical Executive Committee (or Board) has made the following recommendation (decision) which will adversely affect your status as a Medical Staff member (or your appointment to the Medical Staff):

(State the decision or recommendation in full)

The grounds of this recommendation (decision) are:

(Include a detailed statement of the grounds)

You have the following rights with regard to this recommendation (decision): 1) A hearing at which you may be present. You may call and examine witnesses on any matter relevant to the issue of the hearing, challenge witnesses, and rebut any evidence. You may also testify orally in your own behalf. You will be subject to cross-examination. 2) Access to all relevant hospital and medical records prior to the hearing so that you may prepare your defense and response. 3) The right to respond in writing as well as orally at the hearing. The hearing will be conducted by a committee composed of members who have not previously engaged in the investigative process and who have no firm opinion with regard to the recommendation or decision referred to above. The committee decision will be based upon grounds and evidence disclosed to you and to which you will have the opportunity to respond as provided in this letter. 4) You have the right to retain legal counsel to represent you at the hearing. 5) You will have the right to an appellate review by a separate committee, the members of which were not previously engaged in the investigative process and who have no firm opinion as to the recommendation or decision made.

Please indicate your desire to have a hearing in the space appearing at the bottom of this letter and return the copy of this letter in the self-addressed envelope, which has been provided for your convenience. Your failure to request a hearing in writing within thirty (30) days or to attend the hearing without cause after requesting it will be deemed a waiver of your rights. Upon request, a hearing date will be set as soon as practical and you will receive written notice of the hearing date, time and place.

Sincerely,

SIGNATURE
TITLE

I have read the above and request a hearing.

__________________________  ________________________
Date       Name

I have read the above and wish to waive my rights to a hearing.

__________________________  ________________________
Date       Name
ARTICLE VIII: CATEGORIES OF THE MEDICAL STAFF

8.1 Medical Staff Categories
The Medical Staff shall be divided into the following categories: Honorary/Emeritus, Active, Courtesy, Consulting, Active Duty Military, Provisional, Provisional Consulting and Referral Staff.

8.2 HONORARY STAFF
The Honorary Staff shall consist of physicians who are honored by emeritus reputation. The Honorary Staff is not eligible to admit patients, to vote or to hold office and shall have no assigned duties nor pay staff dues. The Honorary Staff shall be appointed by the Board on recommendation of the Credentials Committee.

8.3 ACTIVE STAFF
8.3.1 The Active Staff shall consist of those physicians and oral surgeons who:
   a. have met the general qualifications for membership set forth in Section 3.3; and,
   b. practice within a reasonable distance to the Baptist Health Hospital at which he or she practices in order to provide timely continuous care to his/her patients. Each clinical department is responsible for defining time and/or distance per specialty in the campus Rules & Regulations;
   c. meet the following criteria for demonstration of campus hospital participation:
      1. Physicians and oral surgeons must admit at least twenty-five (25) patients to the hospital or conduct at least thirty-five (35) surgical or interventional procedures, thirty-five (35) consultations, or any combination of these encounters equaling thirty-five (35) (for BMCE and BMCS, and fifty (50) patient encounters for PBH) annually averaged over the prior review period. For PBH, Hospital Based Physicians shall be required to complete ninety six (96) shifts per year, with a shift defined as a twelve (12) hour period which shall not include "on call" time.
      2. Physicians in hospital-based specialties are excluded from the above encounter criteria. The number of active staff positions for these specialties at each campus shall be determined by the campus Medical Executive Committee in consultation with the hospital-based clinical departments and as described in the Rules & Regulations. All other criteria for Active Staff must be met.
   3. The burden of proof for the number of admissions, consultations or procedures shall lie with the practitioner.
   4. Other physicians who do not meet the above patient or hospital encounter criteria, may (1) attend 65% of departmental meetings over the prior review period, and (2) serve on at least two standing, special, or ad hoc committees; or other criteria as specifically developed and published by the campus Credentials and/or Medical Executive Committee.
   d. All Medical Staff members are encouraged to attend all scheduled department meetings to which they are assigned, as well as the annual Medical Staff meeting. Physicians having or desiring active status are required to attend 50% of his/her department meetings per reappointment cycle (per calendar year for PBH – PBH physicians must attend at least fifty percent (50%) of their department meetings per year and may attend a maximum of one (1) other department’s meetings in lieu of their own per year) OR if the physician is assigned to a hospital sanctioned committee, he/she may attend a total of six (6) department/committee meetings per year in any combination. Members may attend other selected Department/Section meetings in lieu of or to make up for missing their own Department/Section meeting with a maximum of two (2) other staff meetings attended per year.

8.3.2 The Active Staff shall have the following duties:
   a. Responsibility for the quality of medical care provided in the hospital. This shall include, (a) participation in the hospital’s performance improvement program, (b) participation in Medical Staff and hospital committees, and (c) support of requirements for institutional accreditation.
b. Transaction of all Medical Staff business. Only active staff members shall be eligible to vote and hold office.
c. Participation in Emergency Department coverage pursuant to EMTALA regulations and per section guidelines.
d. Attendance at medical staff and committee meetings as set forth in Article XII of these Bylaws.
e. Compliance with all provisions of the Medical Staff Bylaws and the Medical Staff Rules & Regulations.

8.4 COURTESY STAFF
8.4.1 The Courtesy Staff shall consist of physicians who (1) have met the general qualifications for membership set forth in Section 3.3; (2) whose practice is within a reasonable distance to a Baptist Health facility at which he or she practices in order to provide timely continuous care to his/her patients. Each clinical department is responsible for defining time and/or distance per specialty in the campus Rules & Regulations; and (3) wish to admit or consult on patients at a Baptist Health facility, but who do not desire to be active and who do not reach the level of activity necessary for Active Staff status.

8.4.2 Courtesy Staff members are not eligible to vote or hold office. They shall be assigned to appropriate clinical departments.

8.4.3 Courtesy Staff members shall have the following duties:
   a. Participation in the hospital's performance improvement program.
   b. Support of requirements for institutional accreditation by the Joint Commission.
   c. Participation in Emergency Department call pursuant to EMTALA regulations and per section guidelines as set forth in each facility’s Rules & Regulations.
   d. Participation in Medical Staff and hospital committees as appointed.
   e. Compliance with all provisions of the Medical Staff Bylaws and Rules & Regulations.
   f. Show competency in the management of care of their hospitalized patients in regard to their specialty.

8.4.4 Appointees to the Courtesy Staff who fail to admit, attend, consult with or otherwise provide care to at least one (1) inpatient and/or outpatient during one appointment period will be deemed to have consented to an automatic transfer to the Referral Staff. Prior to such transfer, the staff member will be notified and given opportunity to contest the transfer. If the staff member provides written justification to the department chair, then the Medical Executive Committee may recommend to the Board that the appointee retain his/her appointment to the Courtesy Staff.

8.5 CONSULTING STAFF
8.5.1 The Consulting Staff shall consist of physicians and oral surgeons who are members of the medical staff, but:
   a. whose practice and/or malpractice coverage is restricted to a specific group of patients; whose practice is outside a reasonable distance to a Baptist Health facility at which he or she practices in order to provide timely continuous care to his/her patients; each clinical department is responsible for defining time and/or distance per specialty in the campus Rules & Regulations;
   b. who have no admitting privileges, but who hold clinics or provide specialized outpatient procedures for their patients at a Baptist Health facility (with appropriate physician backup coverage arrangements as approved by the campus Credentials Committee).

8.5.2 Consulting Staff members are not eligible to vote or hold office. They shall be assigned to appropriate clinical departments.

8.5.3 Consulting Staff members shall have the following duties:
   a. Participation in the hospital's performance improvement program.
   b. Support of requirements for institutional accreditation by the Joint Commission.
   c. Participation in Medical Staff and hospital committees as appointed.
   d. Compliance with all provisions of the Medical Staff Bylaws and Rules & Regulations.
8.6 PROVISIONAL STAFF
8.6.1 The Provisional Staff shall consist of those physicians and oral surgeons who meet the requirements for initial application to the Medical Staff but who are not yet eligible for appointment to the Active or Courtesy Staff.
8.6.2 Provisional staff members shall be eligible for appointment to the Active or Courtesy staff after:
   a. A minimum of one year on the provisional staff; and
   b. Favorable recommendation by the appropriate clinical Department Chairman as set forth in paragraph 4.5.3.
8.6.3 Provisional staff members must be considered for appointment to the Active or Courtesy staff within two (2) years of initial appointment to the Provisional staff.
8.6.4 Duties of Provisional staff members shall be the same as for Active Staff members, except that the Provisional Staff may not vote, hold Medical Staff office or chair a department or medical staff committee. Provisional staff members may be appointed or elected to all Medical Staff committees except the campus Medical Executive Committee.
8.6.5 May be required to take Emergency Department call pursuant to EMTALA regulations and per Section guidelines.

8.7 ACTIVE DUTY MILITARY STAFF (BMCE and BMCS)
8.7.1 The Active Duty Military Staff shall consist of members who are active duty military personnel and who shall only attend patients who are active duty military personnel and/or their dependents. Members of this category of the medical staff shall meet the standards prescribed for Courtesy Staff but shall not be required to comply with the admission requirements. The initial appointment for Active Duty Military Staff shall be for a one (1) year period.
8.7.2 Members of the Active Duty Military Staff shall not be eligible to vote or hold office and shall not take Emergency Department call except for military patients. These members shall not be required, but are encouraged, to attend department meetings and may serve on medical staff committees as determined by the Chief of Staff. These medical staff members shall be subject to bi-annual reappointment.

8.8 REFERRAL STAFF
8.8.1 Eligibility:
   a. The Referral Staff shall consist of physicians who meet the general qualifications for membership set forth in Section 3.3; and
   b. maintain a local office based practice; and
   c. wish to be affiliated with the hospital and to access their patient records, but do not want to admit or provide inpatient care.
8.8.2 Limitations:
   a. Referral Staff members may not admit, write orders for inpatient care, perform surgical or invasive procedures or otherwise treat patients in the Hospital.
   b. Members may visit referred patients in the hospital and review their patient’s medical records, but may not make any entries in any medical record.
   c. Referral Staff may not vote or hold office, nor will they be eligible for advancement to the Active or Courtesy Staff without applying for delineated clinical privileges for that category.
8.8.3 Prerogatives of Referral Staff members:
   a. shall be assigned to appropriate clinical departments, but shall not be delineated clinical privileges.
   b. must comply with all provisions of the Medical Staff Bylaws and Rules & Regulations.
   c. shall not be required to pay medical staff dues, attend department meetings, or be required to participate in the Emergency Department call rotation.
   d. May communicate his/her Referral Staff affiliation in order to satisfy health care plans or managed care organization’s requirements.
8.9 TELEMEDICINE STAFF

8.9.1 Eligibility:
   a. The Telemedicine Staff shall consist of physicians who provide telemedicine consulting services in selected underserved/otherwise unavailable specialties through specific contractual relationships with the hospital.
   b. Who are licensed to practice in the State of Alabama and who are in good standing as members of accredited hospital facilities within or outside the State of Alabama.
   c. Whose membership and privileges in the specialty have been verified by the facility where they are located, which information and verification, after review, has been accepted by the Baptist Health CVO office and the Credentials Committee for the hospital.
   d. Who wish to provide only consultation services for physicians needing assistance in the specialized practice of the telemedicine consultant physician.

8.9.2 Limitations:
   a. Telemedicine Staff members may not admit, write orders for inpatient care, perform surgical or invasive procedures or otherwise treat patients in the hospital.
   b. Telemedicine Staff members may review the EMR, including but not limited to radiographic images, lab or other test results and may enter a consultative note in the EMR suggesting specific care and treatment regimens for patients.
   c. Telemedicine Staff members may not vote or hold office, nor will they be eligible for advancement to the Active or Courtesy Staff without applying for delineated clinical privileges for that category.

8.9.3 Prerogatives of Telemedicine Staff Members:
   a. Shall not be required to pay initial application fees, medical staff dues, are not required to attend department meetings, nor are they required to participate in Emergency Department call.
   b. Recredentialing at their hospital facility shall suffice for recredentialing every two (2) years.
   c. Membership is contingent upon the existence of a contract for services involving the physician and the hospital. Termination of the contractual relationship automatically terminates medical staff membership/privileges.

ARTICLE IX: CLINICAL DEPARTMENTS & HOSPITAL BASED SERVICES

9.1 Organization of Clinical Departments
9.1.1 Clinical Departments
   a. Baptist Medical Center East:
      1. Emergency Medicine
      2. Medicine/Family Medicine/Cardiology
      3. Surgery/Anesthesiology/Pathology
      4. OB/GYN
      5. Pediatrics
      6. Radiology
   b. Baptist Medical Center South:
      1. Anesthesiology
      2. Cardiology
      3. Emergency Medicine
      4. Family Medicine
      5. Medicine (Psychiatry, Neurology, Endocrinology, Dermatology, Oncology, Pulmonology, Gastroenterology, Rheumatology, Nephrology, Infectious Disease, Radiation Therapy, and Hospitalists)
      6. OB/GYN
      7. Pathology
      8. Pediatrics (Neonatology)

c. Prattville Baptist Hospital:
   1. Emergency Medicine
   2. Family Medicine
   3. Medicine/Cardiology
   4. Surgery (Anesthesiology)
   5. Hospital Based Physicians (Hospitalists, Radiology)

At PBH, the Hospital Based Physicians Department shall include the Hospitalists, Radiologists, Anesthesiologists, and Pathologists.

9.1.10 Department Formation, Elimination or Closure
   A medical staff department may be formed, eliminated, or closed, or the performance of a medical procedure within a department may be eliminated, only upon a joint determination and agreement by the affected campus Medical Executive Committee and the Board of the appropriateness of such decision. Such a decision shall be based upon:
   a. proper consideration of the effect on quality and/or delivery of care to patients.
   b. proper consideration of the economic implications of such a decision.
   c. availability of the service within the community/service area from other sources.
   d. a hearing, consolidating the interests of all the affected members, to be held before a panel made up of the Chief of Staff, Chief of Staff-Elect, Immediate -Past Chief of Staff, and the Chairman or the elected representative of the affected department of the medical staff, and the hospital CEO or his/her representative and three (3) members of the Board selected by the Chairman of the Board. Such a hearing shall be held in accordance with Article 7.2.4 et al of the Medical Staff Bylaws except that the hearing shall be limited to the following issues:
      1) whether the determination (formation, elimination or closure) is supported by a preponderance of the evidence; and,
      2) whether the Medical Staff provided appropriate notice to allow comments/input on the issues of appropriateness and effect on Medical Staff membership and privileges.
   e. Except as specified in this Section, the termination of a member’s privileges pursuant to the elimination of a service determined to be appropriate by the campus Medical Executive Committee of the Medical Staff and the Board shall not be subject to further appeal rights as set forth in Section 18.1 of the Medical Staff Bylaws. This is not a reportable event to the National Practitioner Data Bank.

9.2 Requirements for Affiliation with Clinical Departments
   Each department is a separate organizational component of the Medical Staff. Each physician must have a primary affiliation with the clinical department which most closely reflects his/her professional training and experience and the clinical area in which his/her practice is concentrated.

9.3 Qualifications, Selection, and Tenure of Clinical Department Chair/Vice Chair

9.3.1 Qualifications
   Each clinical department Chair/Vice-chair shall be a physician with Active Medical Staff appointment for at least three (3) years (PBH – Active Medical Staff membership only) and shall be board certified in his/her specialty and otherwise qualified by training, experience and demonstrated ability for the position. He/she shall, at nomination, election and continuously thereafter, have a significant portion of his/her practice at the hospital and shall have demonstrated continuing interest in the affairs of the Medical Staff. Except at PBH, each clinical department shall initially elect a Chair and a Vice-Chair, who shall function as chair-elect. At the end of the Chair’s term, the Vice-Chair shall accede to the Chair’s position and a new Vice-Chair shall be elected by the clinical department.
9.3.2 Election
The nomination of the first clinical Department Chair and Vice-Chair shall be accomplished during the first meeting of the department. A list of eligible physicians, who meet the qualifications as set forth in Article IX, Section 9.3.1, will be provided by the Medical Staff Coordinator to the clinical department for selection of nominees for the positions of clinical Department Chairman and Vice-Chairman. Thereafter, every one (1) or two (2) years the clinical Department Vice-Chairman shall assume the role of clinical Department Chairman, and the clinical department shall elect a Vice-Chair. A list of those physicians eligible for nomination as Vice-Chairman shall be furnished by the Medical Staff Coordinator (MSC) to the current Chairman and Vice-Chair. The meeting notification will include an announcement that the Vice-Chair election will occur at the meeting of the department which will be scheduled to take place prior to the Annual Medical Staff meeting. The nomination and election of the Vice-Chair will be placed on the Agenda. The Chairman will provide the list of qualified members to the Active Staff department members present. The Chairman, Vice-Chairman and members of the clinical department will submit nominations. Voting will take place during the regularly scheduled clinical department meeting and shall be decided by a simple majority vote. The new Chairs will submit the name of their new department Vice-Chairmen at the regularly scheduled Medical Executive Committee meeting following the Annual Medical Staff meeting.

9.3.3 Tenure
Each clinical Department Chairman shall serve a one (1) or two (2) year term and the clinical department Vice-Chair shall serve a one (1) or two (2) year term as Vice-Chair and then a one (1) or two (2) year term as Chairman, as determined by the campus Rules & Regulations.

9.3.4 Removal
Removal of a clinical Department Chairman during his/her term of office, or an elected department representative to the campus Medical Executive Committee (BMCS) as referenced in Section 11.4.1.b, may be effected by a two thirds (2/3) vote by secret ballot of all physicians with Active Staff appointment having a primary affiliation with the department. That vote shall be taken at a special department meeting called for that purpose by the campus Medical Executive Committee. No such removal shall be final until reviewed and approved by the campus Medical Executive Committee and the Board.

9.3.5 Replacement of Vacant Chair or Vice Chair Position
Should a Chairman or Vice-Chair resign, otherwise give up his/her position, or be removed from his/her position pursuant to Section 9.3.4, then the following shall occur:
   a. Should the Chair leave office, the Vice-Chair shall take over as Chair.
   b. Should the Vice-Chair leave office, the position shall remain open until an election can be held.
   c. Following any vacancy, the department shall select a nominee to fill the vacant position. The election shall be held at the next regularly scheduled meeting of the department.
   d. For departments solely comprised of exclusively contracted groups, the Medical Director may serve as that department chair for the initial year after which he or she will be required to achieve Active Staff status.

9.4. Functions of the Clinical Department Chairman
The duties, responsibilities, and functions of clinical Department Chairman are as follows:
   a. to monitor all clinically and administratively related activities within his/her department, unless otherwise provided for by the hospital or these Bylaws;
   b. to be a member of the campus Medical Executive Committee, giving guidance to the Committee on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his/her department in order to assure quality patient care;
   c. to coordinate and integrate interdepartmental and intra-departmental services;
   d. to recommend to the campus Medical Executive Committee the criteria for clinical privileges in the department;
   e. to be responsible for implementation within his/her department of actions taken by the campus Medical Executive Committee;
   f. to be responsible for the development, implementation and enforcement of any departmental specific rules or policies as approved by the campus Medical Executive Committee;
g. to transmit to the Credentials Committee his/her department's recommendations concerning the Medical Staff appointment and clinical privileges for all applicants and physicians applying for, or exercising clinical privileges, within the jurisdiction of the department;

h. to assist Administration in determining the qualifications and competence of department personnel who are not Special Limited Staff and who provide patient services;

i. to make recommendations concerning space and other resources needed by his/her department;

j. to coordinate in the quality assessment and improvement activities of the department;

k. to assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the campus Medical Executive Committee, the Chief Operating Officer or the Board;

l. to call special meetings of the department at his/her discretion, with a 72 hour notice by fax and mail out to all department members;

m. to be responsible for communication to and from the campus Medical Executive Committee and the department, and between the department and other departments;

n. to be responsible for transaction of department activities as delineated in the Bylaws and Rules & Regulations of the Medical Staff;

o. to be responsible for orientation and continuing education activities in his/her department;

p. to be responsible for regular attendance at the campus Medical Executive Committee meetings and for presiding at all regularly scheduled meetings of the department;

q. to authenticate minutes, resolutions and other department documents.

r. to assess and recommend to the relevant hospital authority off-site sources for needed patient care service not provided by the department or the organization.

s. to continuously assess and improve the quality of care, treatment and services

t. to recommend a sufficient number of qualified and competent persons to provide care, treatment and services

u. to develop and implement policies and procedures that guide and support the provision of care, treatment and services

v. to integrate the department into the primary functions of the hospital

w. to continually survey the professional performance of all individuals in the department who have delineated clinical privileges

9.5 Functions of the Clinical Department Vice-Chairman

The duties, responsibilities, and functions of the clinical department Vice-Chairman are as follows:

a. Serve as the departmental representative to the Quality Assurance/Quality Improvement Committee.

b. In the absence of, or at the direction of the Chairman, carry out specific or all duties, responsibilities and functions of the Chair, including attendance at the campus Medical Executive Committee meetings with vote.

c. Assume the duties as Chairman of the department at the end of the Chairman’s term or upon the position being otherwise vacated.

d. Such other responsibilities as shall be assigned by the department or these Bylaws.

9.6 Functions of Clinical Departments

The functions of the departments are as follows:

a. To assist in the establishment and to review periodically the existing guidelines for the granting of clinical privileges to individual practitioners, and to evaluate and monitor the clinical quality of section members.

b. To participate fully in the hospital’s performance improvement program to include review of charts and discussions of quality assurance matters.

c. To meet at least quarterly as scheduled to conduct the business of the Department and to review and analyze specifically the department’s clinical quality as it relates to the performance improvement program.

d. To develop and conduct such continuing education activities as the Department shall deem necessary.

e. To comply with standards of the Joint Commission on Accreditation of Healthcare Organizations to assure hospital accreditation.

~32~
f. To submit such reports as shall reasonably be requested by the campus Medical Executive Committee, the Board, or by hospital management.

ARTICLE X: MEDICAL STAFF OFFICERS

10.1 Officers
The officers of the respective campus Medical Staffs shall be the Chief of Staff, Chief of Staff-Elect, Immediate-Past Chief of Staff and except at PBH, a Secretary/Treasurer.

10.2 Qualifications
A medical staff member considered for office shall be a physician with an Active Staff appointment for at least five (5) years, (no time limit at PBH) shall be board certified in his/her specialty, and/or otherwise qualified by training, experience and demonstrated ability for the position. A significant portion of the physician’s practice shall be located at the campus where he/she will serve as a Medical Staff officer.

10.3 Election of Officers

10.3.1 Nominating Committee

a. Composition:
The committee shall be comprised of the department chairmen of Medicine, Family Medicine, Surgery, Obstetrics/Gynecology, Pediatrics, and one seat rotated annually or biennially between hospital-based departments taken in alphabetical order (Anesthesiology, Emergency Medicine, Pathology, and Radiology). The Chairperson of the committee shall be the Chief of Staff-Elect who shall serve without a vote. The officer nominees shall be determined by majority vote of the committee. At PBH, the Medical Staff Executive Committee functions as the Nominating Committee.

b. Duties:
The duties of the committee shall be to nominate one or more willing and qualified candidates for the positions of Chief of Staff-Elect and Secretary/Treasurer.

c. Meetings:
The committee shall meet annually at least 60 days prior to the Annual Medical Staff meeting [August] and shall communicate their nominations to the Medical Staff Coordinator following the meeting.

d. The nominations shall be sent to the Active Staff via Fax or mail at least 30 days prior to Annual Meeting of the Medical Staff. Nominations for the ballot may also come from the floor at the Annual Meeting pursuant to the qualifications as set forth in Article 10.2 of these Bylaws.

10.3.2 Officers shall be elected at the Annual Meeting of the staff in October (PBH – Dec) each year.

10.3.3 Each member of the Active Staff present shall be eligible to cast a secret ballot for one candidate for each office.

10.3.4 The candidate receiving a majority of votes from the Active staff members for each office shall be elected. If no candidate receives a majority vote on the first ballot, a runoff election shall be held at once between the two candidates receiving the highest number of votes.
10.4 Term of Office
Term of office can be one (1) year or two (2) years depending on the campus specific Rules and Regulations, beginning on January 1 of the year following the election.

10.5 Vacancies
Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by the campus Medical Executive Committee. If there is a vacancy in the office of Chief of Staff, the Chief of Staff-Elect shall serve out the remaining term.

10.6 Duties of Officers

10.6.1 Chief of Staff
The Chief of Staff shall:

a. Act as the chief medical officer of the hospital in coordination and cooperation with hospital management in matters of mutual concern involving the hospital.
b. In conjunction with the campus Medical Executive Committee, be accountable to the Board for the quality of professional performance by the Medical Staff.
c. In conjunction with the campus Medical Executive Committee, be accountable to the Board for the continuous accreditation of the hospital by the Joint Commission on Accreditation of Healthcare Organizations.
d. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
e. Serve as chairman of the campus Medical Executive Committee, and as an ex-officio member without vote of all other Medical Staff committees.
f. In conjunction with the clinical Department Chairmen, be responsible for the enforcement of these Medical Staff Bylaws and the Rules & Regulations.
g. Receive and interpret the policies of the hospital and the Board to the Medical Staff; and serve as liaison between the Medical Staff, Board, and hospital administration.
h. Participate in the enforcement of disciplinary sanctions imposed by the Medical Staff, Board or hospital Administration.
i. Request recommendations from Department Chairmen to assist in making appointments and based on same appoint Committee Chairmen and members to all standing and ad hoc Medical Staff committees, except the Medical Executive Committee and Credentials Committee.
j. Assist in the granting of temporary privileges to practitioners.
k. Assist in the reassignment of hospital patients when a staff member’s privileges are suspended or terminated.
l. Be the general spokesman for the Medical Staff in its internal and external professional and public relations.
m. Serve on the Physician Council.
n. Serve as an advisory member to the Board.

10.6.2 Chief of Staff-Elect
a. The Chief of Staff-Elect shall be a member of the campus Medical Executive Committee and Chairman of the Quality Assurance/Quality Improvement Committee. In the absence of the Chief of Staff, he shall assume all the duties and authority of the Chief of Staff.
b. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff-Elect shall serve out the remaining term.

10.6.3 Secretary-Treasurer (BMCE and BMCS)
The Secretary-Treasurer shall be a member of the campus Medical Executive Committee and Chairman of the Medical Records/Utilization Review Committee. His duties shall include:
a. Review and approval of all campus Medical Executive Committee minutes.
b. Signing medical staff correspondence as requested.
c. Periodic reports on funds collected as medical staff dues or assessments.
d. Signatory on medical staff bank accounts.
e. Performance of all other duties ordinarily pertaining to the Secretary-Treasurer.
10.6.4 Immediate-Past Chief of Staff
   a. Shall be a member of the campus Medical Executive Committee.
   b. Shall perform advisory duties as assigned to him/her by the Chief of Staff, campus Medical Executive Committee, or the Board.

10.7 Removal of Officers
The campus Medical Executive Committee, with a two thirds (2/3) vote, and the Active Medical Staff, with two thirds (2/3) of votes cast, and with approval of the Board, may remove any Medical Staff officer for conduct detrimental to the interests of the Medical Staff, or if he/she is suffering from a physical or mental infirmity that renders him/her incapable of fulfilling the duties of his/her office. The officer shall be afforded the opportunity to speak on his/her own behalf before the campus Medical Executive Committee and the Active medical staff at a special meeting of the Active medical staff called for that purpose prior to taking any vote on his/her removal. Notice of the meeting shall have been given in writing to such officer at least fifteen (15) days prior to the date of such meeting as referenced in Article XII, 12.2 – Special Meetings.

ARTICLE XI: MEDICAL STAFF COMMITTEES

11.1 General
11.1.1 Committees shall be of two types, either standing or special. Standing committees are appointed to fulfill ongoing requirements of the Medical Staff organization. Special or ad hoc committees are appointed as needed and are charged with a specific responsibility. Once that responsibility has been satisfied, these committees are disbanded.
11.1.2 Unless otherwise provided for in these Bylaws, all Medical Staff members of committees shall be appointed by the Chief of Staff.
11.1.3 The Chairman of any standing or special committee must be an Active staff member, and the physician committee members must be Active, Courtesy or Provisional staff members.
11.1.4 The Chief of Staff and the hospital CEO and their respective designees shall be ex-officio members without vote of all appointed committees.
11.1.5 The Chief of Staff-Elect will make standing committee appointments prior to taking office January 1. Standing committee appointments shall be for one year, beginning on January 1 following elections.
11.1.6 Appointees to a committee shall attend at least 50% of the official committee meetings. Records of attendance shall be maintained and considered as part of the medical staff reappointment process.
11.1.7 The Chief of Staff may, at his pleasure, replace any physician member of a special or standing committee unless otherwise prohibited in these Bylaws.
11.1.8 If any of the standing committees outlined in the following sections is not currently established at a given campus, then the campus Medical Executive Committee shall assume the role of the committee or may elect for a committee to be formed according to the Bylaws.

11.2 Standing Committees
The standing committees of the Medical Staff shall be:
   a) Physician Council (Joint Committee)
   b) Campus Medical Executive Committee
   c) Credentials Committee (BMCS only)
   d) Quality Assurance/Quality Improvement Committee
   e) Utilization Review/Medical Records Committee
   f) Pharmacy & Therapeutics Committee
   g) Infection Control Committee
   h) Bylaws Committee (Joint Committee)
   i) Therapeutic Termination of Pregnancy Committee (BMCS only)
   j) OR Advisory Committee (BMCS only)
   k) Radiation Safety Committee (Joint Committee)
   l) Institutional Review Committee (Joint Committee)
m) Ethics Committee
n) GI Advisory Committee (determined by campus need)
o) Blood Utilization Committee (BMCS only)
p) Trauma Systems Committee (BMCS Only)
q) Physician Information Technology (IT) Committee (Joint Committee)

11.3 Physician Council

11.3.1 Composition

The Physician Council shall consist of nine (9) Active Staff members, three (3) from each campus. The council membership shall include the Chiefs of Staff from each campus and two (2) members from each campus selected by one of the two methods as determined by the respective Medical Executive Committees:

a. The two (2) members may be the immediate-Past Chief of Staff and the Chief of Staff-Elect; or
b. Two (2) Active Staff members may be elected at the Annual Meeting of the Medical Staff.

11.3.2 Duties

a. To assist the campus Medical Executive Committees in reaching consensus on issues that affect all campus Medical Staffs, such as physician privileges, credentialing, bylaw changes, appointments, and disciplinary action.
b. Shall meet on a called basis when the need arises as determined by the Medical Executive Committee of a campus or the Board.
c. Shall act solely in an advisory capacity to the campus Medical Executive Committees.
d. Shall maintain a permanent record of its proceedings and make these available to all campus Medical Executive Committees and the Board.

11.4 Campus Medical Executive Committee

11.4.1 Composition

a. Baptist Medical Center East: The Campus Medical Executive Committee shall consist of the officers of the Medical Staff and the Chairman of each of the approval clinical departments of the hospital.
b. Baptist Medical Center South: The Campus Medical Executive Committee shall consist of the officers of the Medical Staff, the Chairman of the Credentials Committee, the Chairmen of each of the approved clinical departments of the hospital, and the Program Chairman from each of the Graduate Medical Education Programs. In addition, four (4) additional elected representatives shall serve: one (1) from the Medicine Department, one (1) member of the Hospitalist group elected by the Internal Medicine and Family Medicine departments, and two (2) from the Surgery Department. The department representatives, who must be Active Staff members, shall be nominated and elected at the regular meeting of their department preceding November 1\textsuperscript{st} and assume membership on the BMCS Medical Executive Committee at its January meeting. The representative from Medicine, the Hospitalist representative and one (1) from Surgery shall be elected in odd years, and the other representative from Surgery shall be elected in even years. All terms shall be for two (2) years.
c. Prattville Baptist Hospital: The Campus Medical Executive Committee shall consist of the Chief of Staff (two (2) year term), the Vice Chief of Staff (two (2) year term), the Immediate Past Chief of Staff (two (2) year term), the Chairmen of each of the approved clinical departments of the hospital (two (2) year term) and the Hospital CEO and the Chief Nursing Officer of the hospital as ex-officio members. The number of members of any one (1) department who may serve on the Committee at any one time shall be limited to two (2) each from the Departments of Surgery, Family Medicine, Internal Medicine, Hospital Based Physicians and Emergency Medicine.
11.4.2 Duties

a. Receive and act upon reports and recommendations of all clinical departments, committees and officers.

b. Coordinate the activities and general policies adopted by the Medical Staff, its clinical departments and committees.

c. Fulfill the Medical Staff’s accountability to the Board for the quality of medical care rendered by the medical staff to patients at Baptist Health. This shall include responsibility to maintain quality improvement programs required by the various statutory professional licensure or accreditation agencies, and to encourage continuing medical education programs.

d. To represent and act on behalf of the Medical Staff between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws. The Medical Staff, in accordance with Article 20, may submit a revision to the bylaws to remove this authority.

e. Initiate and pursue corrective action, when warranted, as specified in Articles VI and VII of these Bylaws.

f. Consider and make recommendations to the hospital CEO on matters of a medical/administrative nature.

g. Meet at least ten (10) times a year and maintain a permanent record of all proceedings and actions taken.

h. Call a special meeting as requested by the Chief of the Medical Staff.

i. Review annually the HCA Director and Officers professional liability insurance policy, including the certification of, to insure coverage for Medical Staff leadership positions.

j. Review annually the Board’s Corporate Bylaws, Rules & Regulations, policies and procedures.

k. The Medical Staff delegates’ responsibility for developing bylaws, rules and regulations and credentialing and hospital clinical policies to the campus Medical Executive Committee as defined in Articles 19-21.

l. The Medical Staff, by its approval of the bylaws, hereby delegates responsibility set forth in the bylaws unless otherwise stated.

11.5 Credentials Committee (BMCE & PBH- MEC performs the functions of the Credentials Committee).
This committee is specific to BMCS (10/04)

11.5.1 Composition

a. The Credentials Committee shall be made up of seven (7) members being chosen from the following departments by the Chief of Staff:

1. One (1) member selected from the Medicine / Family Medicine Departments.
2. One (1) member selected from the Surgery Department.
3. One (1) member selected from the Obstetrics/Gynecology Department.
4. One (1) member selected from the Pediatrics Department.
5. One (1) member selected from the Department of Anesthesiology, Pathology or Radiology on a rotating basis.
6. One (1) member selected from the Emergency Medicine Department.
7. One (1) member selected from the Cardiology Department.

b. Members selected must have previously served as Department Chairmen or as members of the campus Medical Executive Committee, or have been a member of the Active Staff for a period of ten (10) years and are subject to approval by the campus Medical Executive Committee.

c. Committee membership term is two (2) years. Members may serve consecutive terms if so desired by the incoming Chief of Staff and if the member is willing to serve.

d. The Credentials Committee shall elect a chairman from their membership every two (2) years with the first term effective January 1, 2012.

e. Service on this Committee shall be considered to be the primary medical staff obligation of each member and he/she must attend at least a majority of the meetings held.
Committee members shall not be required to attend any other meetings or serve on any other committees (except for attendance at the Annual Medical Staff meeting).

g. Should the Chairman or one of the members withdraw from service on the committee during the tenure of his/her term, then the Chief of Staff will appoint another appropriate member.

h. If a Credentials Committee is not currently established at a given campus, the campus Medical Executive Committee will act as the Credentials Committee. A Credentials Committee may be formed as outlined in Article 11.5 of the Medical Staff Bylaws.

11.5.2 Duties

a. To review the completed applications and credentials of all applicants for medical staff appointment, reappointment, and clinical privileges; to make investigations of and to interview, if desired, such applicants or others having information relative to the application. Following the review process, the committee shall make a report of its findings and recommendations to the campus Medical Executive Committee for its approval and submission to the Board for final action.

b. To review the completed applications and credentials of all applicants who request to practice as Special Limited Staff, or Allied Health Professionals.

c. To establish criteria for the granting of specific clinical privileges subject to approval by the campus Medical Executive Committee.

d. The Credentials Committee shall maintain a permanent record of its proceedings, and submit a monthly report of its findings and recommendations to the campus Medical Executive Committee for its approval and submission to the Board for final action.

11.6 Quality Assurance/Quality Improvement (QA/QI) Committee

11.6.1 Composition

a. The Quality Assurance/Quality Improvement Committee shall be made up of the Vice-Chairs of the campus clinical departments and others as defined in the Baptist Health Quality Improvement Program with the Chief of Staff-Elect of the medical staff acting as its Chairman.

b. This committee shall oversee the hospital’s quality improvement programs which shall include all aspects of clinical care rendered by physicians, as well as services provided by the hospital. The committee shall adopt, subject to approval by the campus Medical Executive Committee and by the Board, specific programs and procedures for monitoring, evaluating and maintaining the quality and appropriateness of clinical care and services within the hospital. These quality improvement programs shall be sufficient to meet the requirements of the Joint Commission and shall contain mechanisms for (a) establishing objective criteria (b) measuring actual practice variations from criteria (c) analyzing measurements by peers (d) taking appropriate action to identify problems, (e) reporting opportunities to improve patient care to hospital administration, the Medical Staff, and the Board. This committee shall conduct its quality improvement functions using the strictest measures of confidentiality. Based upon its review, the QA/QI Committee shall make recommendations to the campus Medical Executive Committee. Any action or follow up review activity approved by the campus Medical Executive Committee shall be implemented and enforced.

c. This committee shall itself, or through a subcommittee or subcommittees, review medical and surgical cases to assure that the medical care rendered and that the surgical procedures performed are justified and of high quality. The committee, or subcommittee(s) as the case may be, shall determine the scope of medical and surgical cases to be reviewed. In any event, all cases in which a major discrepancy exists between the admitting/pre-operative and discharge/postoperative (including pathologic) diagnoses shall be reviewed.

d. Subcommittees of the Quality Assurance/Quality Improvement Committee include:
   • Mortality and Morbidity Committee (M&M) (BMCS only)
   • Neonatal Mortality and Morbidity Committee
   • Trauma Performance Improvement / Peer Review Committee (BMCS only)
Each of these subcommittees meets regularly to review identified peer review cases and report to the QA/QI Committee when appropriate.
e. The Quality Assurance/Quality Improvement Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions.

11.7 Utilization Review/Medical Records Committee

11.7.1 Composition
The Utilization Review/Medical Records Committee shall consist of a broad cross-section of the medical staff. In addition, the membership shall include an administrative representative, the Chief Nurse Officer (CNO), the hospital legal counsel, the Director of Medical Records and the Director of Quality Management. The Secretary-Treasurer of the medical staff shall serve as Chairman of the Committee.

11.7.2 Duties
a. The committee shall review and monitor the status of patient medical records to assure that the records meet an acceptable standard for historical validity and timely completion. The committee shall conduct periodic reviews to determine whether promptness, clinical pertinence, accuracy and timeliness meet the criteria established in the Rules & Regulations of the Medical Staff. The committee shall ensure that the medical records function is adequate to meet the requirements of the Joint Commission, and that appropriate Rules & Regulations are established and enforced so that medical records are completed within time limits dictated by Medicare and other third party payors.
b. The committee shall review and make recommendations to the campus Medical Executive Committee and to administration concerning policies related to medical record completion, formats, filing, storage and availability, and shall approve forms to be included in the medical record.
c. The committee shall be responsible for utilization review activities assigned to it by the Utilization Review Plan and shall perform those utilization review functions necessary to meet the requirements of the Joint Commission.
d. The committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions.

11.8 Pharmacy & Therapeutics Committee (Handled by Medical Executive Committee at PBH)

11.8.1 Composition
The Pharmacy & Therapeutics Committee shall consist of medical staff representatives, two (2) representatives from the hospital Pharmacy, one (1) representative from the Dietary Department, one (1) representative from the Laboratory, one (1) representative from Administration, and the Chief Nurse Officer (CNO).

11.8.2 Duties
The Pharmacy & Therapeutics Committee shall supervise the development of policies and procedures that govern the safe administration of drugs within the hospital. These shall include the evaluation, appraisal, selection, procurement, distribution, use, safety procedures and all other matters relating to drugs in the hospital. The function of the committee shall include the ongoing monitoring of the use of drugs and the continuous evaluation of hospital drug procedures:
a. Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.
b. Annual review of the hospital formulary.
c. Report to the Medical Executive Committee and Quality Improvement Committees on a quarterly basis.
d. Meet on at least a quarterly basis and maintain a permanent record of its proceedings and actions.

11.9 Infection Control Committee

11.9.1 Composition
The Infection Control Committee shall consist of an appropriate number of members of the medical staff selected by the Chief of Staff and appropriate members of the hospital staff selected by the CEO, and are chaired by an Internist, Pathologist or other physician with an interest in infectious disease.

11.9.2 Duties
a. The committee shall advise the campus Medical Executive Committee and the hospital administration on all matters relating to hospital infections and their control and prevention.
b. The committee shall be responsible for reviewing infection control functions as required by the Joint Commission.
c. The committee shall meet at least quarterly, or on the call of its chairman, shall maintain a permanent record of its actions and proceedings, and shall report to the quality improvement committee on a quarterly basis.

11.10 Bylaws Committee
11.10.1 Composition
a. The Bylaws Committee of each campus shall consist of four (4) members of the Active Staff representative of the medical staff of each campus. The Baptist Health legal representative shall serve as an ex-officio member of the committee.
b. The Joint Bylaws Committee shall consist of all the members of the campus Bylaws Committees. The Baptist Health legal representative shall serve as an ex-officio member of the committee.

11.10.2 Duties
a. This committee shall be responsible for receiving and considering all requests for revisions to the Medical Staff Bylaws.
b. The committee shall be responsible for periodic review and revision of the Bylaws consistent with Joint Commission requirements.
c. Service on this committee shall be considered to be the primary medical staff obligation of each member and he/she must attend at least a majority of the meetings held. Committee members shall not be required to attend any other meetings or serve on any other committees (except for attendance at the Annual Medical Staff meeting).
d. The Joint Bylaws Committee shall meet on at least an annual basis, or on the call of the Chief of Staff of either campus or its Chairman, shall keep a permanent record of its proceedings and actions, and report same to the campus Medical Executive Committees.

11.11 Therapeutic Termination of Pregnancy Committee (BMCE and BMCS)
11.11.1 Composition
a. The committee shall consist of three staff physicians, with the OB/GYN Department Chairman serving as Chairman.
b. At least two of the three committee members must be present to consider a request.
c. Neither the requesting physician nor a professional associate may sit on the committee.
d. In the event that two (2) eligible members of the committee cannot be available to hear a request, the Chief of Staff or any other medical staff officer may temporarily serve as a member of the Therapeutic Termination of Pregnancy Committee.

11.11.2 Duties
a. The function of the committee is to judge the medical necessity of each proposed termination of pregnancy in accordance with the laws of the State of Alabama. The committee shall conduct business according to policies and procedures developed by the committee and approved by the campus Medical Executive Committee and the Board.
b. In all cases involving a termination of pregnancy, the requesting physician shall submit the patient’s detailed case history for committee review.
c. This is a special committee called when needed to consider the medical necessity of the requested termination of pregnancy and shall forward its decision to the requesting
physician. In the event a termination of pregnancy is approved, all materials pertaining to the case shall be forwarded to the patient’s medical record. Appropriate consent forms will also be obtained and forwarded to the patient’s medical record.

d. A record of each termination of pregnancy shall be made and kept in the medical staff files. This record shall include copies of all information pertinent to the case including a pathologist’s report.

11.12 OR Advisory Committee
11.12.1 Composition
The OR Advisory Committee is a self-perpetuating committee composed of medical staff members of the Department of Surgery, who are governed by a set of Rules & Regulations adopted by the Department of Surgery. This committee will be campus specific.

11.12.2 Duties
a. The OR Advisory Committee has the function of bringing physicians, Administration, OR management, and the Anesthesiology Department together into a cohesive body to promote good medical care and address care issues necessary for the efficient and safe functioning of the operating room.

b. The committee shall meet at least quarterly, shall keep a permanent record of its proceedings and actions, and shall report at least quarterly to the Department of Surgery and the Quality Assurance/Quality Improvement Committee.

11.13 Radiation Safety Committee
This committee shall include medical staff members from Radiology, Nuclear Medicine, and a representative from Radiation Therapy as well as the administrative department heads from Radiology and Nuclear Medicine. The hospital CEO, or designee, and the System Radiation Safety Officer shall also be members. The hospital's radiation physics consultant shall serve as a non-voting member. The duties of this committee shall be to help the hospital maintain compliance with all statutory requirements for safe handling, storage, usage and disposal of radioactive materials associated with the hospital's institutional radioactive materials license. In addition, the committee shall review and make recommendations concerning general radiation safety procedures for patients and hospital staff, and assist with compliance with Joint Commission related requirements. This shall be a joint committee with representatives from both campuses.

11.14 Institutional Review Committee
11.14.1 Composition
The IRC shall consist of at least nine (9) members, with varying backgrounds, experience and expertise to adequately review research activities conducted at Baptist Health controlled facilities. At least one (1) member of the committee shall not be otherwise associated with BH (or its affiliates) nor a member of the immediate family of a person who is affiliated with the hospital (or its affiliates). At least four (4) members shall be physicians on the medical staff of a Baptist Health facility. In addition, four (4) alternate physician/non-physician memberships may be maintained at any time. The System Director of the Pharmacy and the Baptist Health Legal Counsel shall also serve as members. IRC members shall not be from a single professional group and shall not consist entirely of men or entirely of women. At least one (1) member's background or profession must be in a non-scientific area.

11.14.2 Duties
The IRC shall review all research involving investigational drugs and medical devices performed at Baptist Health controlled facilities. The committee may also, at its discretion, review and approve research performed on outpatients provided such research is conducted by any Active Staff appointee at BH. The committee may approve, modify or disapprove protocols or other proposed investigational research based upon considerations concerning human subject protection. The committee may also suspend and/or terminate a research project in progress, or place irreversible restrictions on said project when appropriate for the protection of human subjects. The IRC's decisions impact all Baptist Health related facilities.
11.15 Ethics Committee (Handled by Medical Executive Committee at PBH)

11.15.1 Composition
Each campus hospital shall have an Ethics Committee whose membership shall include at least four (4) physicians appointed by the Chief of Staff, at least two (2) nursing staff members, and representatives from Pastoral Care, Administration, and legal counsel.

11.15.2 Duties
a. The purpose of the Ethics Committee is to participate in development and implementation of procedures for the review of cases having ethical implications; development and/or review of campus specific policies regarding care and treatment of patients with ethical implications; retrospective review of cases by the group to identify opportunities for improvement as well as for the purpose of committee education; provide consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the hospital staff on ethical matters.
b. The Committee shall meet on a regular basis as determined by the Chair. In addition to regular meetings, the Committee may be convened upon the request of a patient, employee, Medical or Allied Health Staff, or other individual for the purpose of addressing ethical issues. A permanent record of its proceedings and actions shall be maintained.
c. The campus Ethics Committee policies & procedures shall govern the scope of responsibilities of the Ethics Committee.

11.16 GI Advisory Committee (Handled by Medical Executive Committee at PBH)

11.16.1 Composition
The GI Advisory Committee is composed of physicians with endoscopy privileges and the Endoscopy Nurse Manager, who are governed by a set of Rules & Regulations adopted by the Departments of Medicine and Surgery. This committee will be campus specific.

11.16.2 Duties
a. The GI Advisory Committee brings physicians, administration and nursing management together into a cohesive body to promote quality medical care and address issues necessary for the efficient and safe functioning of the Endoscopy Department.
b. This is a special committee called when needed and shall keep a permanent record of its proceedings and actions.

11.17 Blood Utilization Committee (BMCS Only)

11.17.1 Composition
The Blood Utilization Committee shall be chaired by the Chairman of the Department of Pathology, and shall consist of medical staff representatives from the following specialties: Anesthesiology, Cardiovascular Surgery, General/Vascular Surgery, Neonatology, Orthopedics, Medicine, Emergency Medicine, representatives from both residency programs, as well as representatives from Quality Management, the Laboratory, and Nursing Administration.

11.17.2 Duties
The committee shall supervise the safe and effective use of blood and components within the hospital, including the following functions:
a. Develop and implement transfusion policies and procedures.
b. Facilitate collaboration among clinical disciplines to ensure that policies and procedures for transfusion therapy conform to the applicable regulations.
c. Evaluate and implement, when appropriate, blood management techniques and alternatives to transfusion.
d. Oversee creation and implementation of transfusion educational modules.
e. Coordinate continuing education of nurses, physicians, and blood bank laboratory staff in transfusion safety.
f. Monitor blood utilization and provide oversight for hospital-wide peer review.
g. Reactive: Participate in root-cause analysis (RCA) of transfusion-related adverse events and ensure RCA recommendations are disseminated, implemented, and evaluated for effectiveness.
h. Proactive: Improve patient safety through the implementation of ongoing proactive assessment and performance improvement in blood ordering, blood sample collection, blood issuance, pre-transfusion bedside clerical checking, and transfusion-reaction reporting practices.

i. Review and analyze blood bank reports, e.g., regarding blood use, blood losses, adverse reactions and transfusion errors and accidents.

j. Present blood utilization reports to the accreditation and regulatory agencies as needed.

k. Maintain a cooperative relationship with the regional blood center.

l. Involve the blood center in staff education, disease surveillance, and follow-up of suspected cases of transfusion-related acute lung injury.

m. Meet on at least a quarterly basis, maintain a permanent record of its proceedings and actions, and send a report to the QA/QI Committee and medical staff departments.

11.18 Trauma Systems Committee (BMCS Only)

11.18.1 Composition

The Trauma Systems Committee shall be chaired by the Trauma Program Medical Director and shall consist of medical staff representatives from the following specialties: Anesthesiology, Neurosurgery, General/Trauma Surgery, Emergency Medicine, Orthopedics, Cardiovascular/Thoracic, Radiology, as well as representative from Quality Management, Nursing Administration, the Laboratory, PT/OT/Speech Therapy, Social Work/Case Management, Trauma Program Nursing Director, Trauma Coordinator, and Nurse Managers from the following nursing units: Operating Room, SICU, NSICU, Emergency Department, 6N, 4N, and 4S.

11.18.2 Duties

The primary purpose of the committee is to deliver optimal care to injured patients treated at BMCS by having a multidisciplinary team to develop performance improvement strategies. The care of the injured patient depends on a complex network of people working together as a team. The emergent nature of trauma care relies on each member of the team to perform well on a regular basis. The committee is designed to monitor the performance improvement and determine ways in which it can improve trauma care.

11.19 Physician Advisory Leadership Group (PALG) (Joint Committee)

11.19.1 Composition

The Physician Advisory Leadership Group is chaired by the Chief Medical Information Officer (CMIO) and consists of a broad cross-section of medical staff members from each hospital appointed by the CMIO in consultation with both campus Chiefs of Staff.

11.19.2 Duties

1. Foster a healthcare IT culture among the medical staff.
2. Recommend workflow changes and design decisions that are standardized and evidence-based best practice.
3. Participate in ongoing order set review and approval.
4. Center decisions on patient safety, quality of care, and physician adoption/ease of use.
5. Recommend and/or develop any pertinent policies, procedures, rules, regulations and bylaws.
6. Recommend training plans and adoption strategies
7. Report updates to the Medical Executive Committee and physician departmental meetings.
ARTICLE XII: MEETINGS

12.1 Annual Meeting
The Annual Meeting of the Medical Staffs at each campus shall be held in October on a date approved by the campus Medical Executive Committee. Medical Staff Officers, Committee Chairmen, and others may make reports. Medical Staff Officers shall be elected at the annual staff meeting as noted in Section 10.3.

12.2 Special Meetings
Special meetings of the Medical Staff may be called at any time by the Chairman of the Board, the Chief of Staff, a campus Medical Executive Committee, or any ten (10) members of the Active Staff by petition to the campus Medical Executive Committee. Special meetings will be scheduled to be held within thirty (30) days of their being called. Notice of a special meeting will be faxed and mailed to medical staff members and must also be posted in the Medical Records chart room at least seven (7) days before the scheduled meeting. Only the business for which the meeting has been called may be transacted.

12.3 Clinical Department Meetings
Clinical Department meetings shall be held at least quarterly.

12.4 Attendance at Meetings
12.4.1 All Medical Staff members are encouraged to attend all scheduled department meetings to which they are assigned, as well as the Annual Medical Staff meeting. Physicians having or desiring Active status are required to attend 50% of his/her department meetings, OR if the physician is assigned to a hospital sanctioned committee, he/she may attend a total of six (6) department/committee meetings in any combination. Members may attend other selected department/section meetings in lieu of or to make up for missing their own department/section meeting with a maximum of two (2) other staff meetings attended per year.

12.4.2 Active and Provisional staff members will be reminded that failure to comply with attendance requirements will result in their being placed on the Courtesy staff at their next reappointment cycle. Approximately six months prior to the expiration of their current appointment/reappointment period, staff members will be notified by certified letter from the Credentials Verification Office if the number of required meetings attended has not been met. (10/04)

12.4.3 Members of the Courtesy and Honorary Staffs, as well as members of the Credentials and/or Bylaw Committees, are not required to attend departmental/section meetings, but are encouraged to do so.

12.4.4 Attendance at staff meetings will be considered as a factor in the reappointment process.

12.4.5 All meetings of the Medical Staff shall be governed by the current edition of Roberts Rules of Order.

12.5 Quorum
Fifty percent of the total membership of the Active Staff shall constitute a quorum at the Annual Medical Staff meeting or at any called special meeting. Fifty percent of the membership of the Medical Executive Committee shall constitute a quorum.

12.6 Official Medical Staff Year
The official medical staff year shall be January 1st through December 31st.

ARTICLE XIII: DUES

13.1 Staff Dues (Appointment / Reappointment Fees)
13.1.1 Annual dues and/or other assessments of the Medical Staff shall be set by the campus Medical Executive Committee. Medical Staff dues shall be collected at the time of appointment and reappointment. All members except honorary staff members are required to pay dues.
13.1.2 Dues are required to be submitted (paid) at the time the application (new or reappointment) is submitted to the Credentials Verification Office (CVO). The CVO will notify the applicant in writing up to two (2) times if dues are not received. If the CVO has not received dues within 30 days of the deadline for processing the application, the campus Medical Executive Committee Chairman will be called upon to assist with the collection of dues. For initial appointments, processing of the application will be withheld until receipt of the dues. Failure to pay dues for a reappointment application will result in suspension from the Medical Staff. The campus Medical Executive Committee shall be authorized to waive the payment of dues in appropriate instances.

13.1.3 Dues will be used to purchase medical books, periodicals, to bind periodicals, for educational purposes, and such other Medical Staff related projects as shall be approved by the campus Medical Executive Committee.

ARTICLE XIV: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at Baptist Health:

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

Second, that, such privilege shall extend to members of the hospital’s Medical Staff and its Board, its other practitioners, the chief executive officer and his representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XV, the term “third parties” means both individuals and organizations from which information has been requested by an authorized member of the Board or of the Medical Staff.

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

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

1. Applications for appointment or clinical privileges
2. Periodic reappraisals for reappointment or clinical privileges
3. Corrective action, including summary suspension
4. Hearings and appellate review
5. Quality review functions
6. Other hospital, departmental, service or committee activities related to quality patient care and inter-professional conduct.

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article XIV may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that the consents, authorizations, releases, rights, privileges and immunities provided by Section 1 of Article IV of these Bylaws for the protection of this hospital’s practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV.

Seventh, every physician who serves as Chief of Staff, head of a Medical Staff department, a member of a staff peer review committee or quality committee or acts in any hospital and/or Medical Staff administrative capacity, absent of malice, should be fully indemnified and held harmless by the hospital in the same manner and in at least the same monetary amounts as is the HCA for Baptist Health Board of Directors. The Board must provide proof of adequate insurance coverage to the Medical Staff. The above also applies to peer review, credentialing, or other administrative acts involving LLPs, Allied Health Professionals, and Special Limited Staff members. The hospital shall defend and assume the costs incurred for defense and pay any settlements, judgments, and damages on behalf of any member of the Medical Staff arising out of service on any hospital or medical staff committee or assisting in peer and professional review.
or quality assurance activities involving care provided at the hospital so long as the member acted in good
faith.

**ARTICLE XV: LIMITED LICENSED PROFESSIONALS**

15.1 Definition
Limited Licensed Professionals (LLP) means an individual, other than a physician or oral surgeon, who is licensed in the State of Alabama to practice in one or more areas of independent healthcare delivery. To the extent authorized by the Board, LLP may apply for clinical privileges and exercise such clinical privileges as may be granted pursuant to these Bylaws.

15.2 Appointment/Reappointment
15.2.1 Appointment of a LLP is solely at the discretion of the Board.
15.2.2 A LLP must apply for specific clinical privileges and exercise such specific clinical privileges as may be granted pursuant to these Bylaws.
15.2.3 The Credentials Committee/Medical Executive Committee of each respective campus shall determine the needs of any area of medical practice that may require the credentialing of a LLP as defined in 15.1.1 above.
15.2.4 The appointment / reappointment credentialing process shall be identical to the process outlined under Article IV (Appointment / Reappointment) of these Bylaws.

15.3 Limits of Privileges
15.3.1 A LLP shall not independently deliver patient care within the hospital without the oversight of an attending / admitting staff physician who will be ultimately responsible for the patient’s total care. Care delivered by the LLP is limited to those services for which specific clinical privileges were granted.
15.3.2 All LLP members of the Medical Staff must comply with statutory and licensure regulations of the State of Alabama regarding clinical privileges.

15.4 Limits of Activities
15.4.1 No clinical privileges other than those specifically granted by the Board may be performed by the LLP.
15.4.2 Limits of clinical activities for LLP may be prescribed by the Credentials Committee at any time, specific to the respective campus and subject to approval by the Board.
15.4.3 The Credentials Committee may establish, amend and enforce rules and regulations for the LLP subject to approval by the Board.

15.5 Temporary Approval
The hospital CEO may grant temporary approval to applicants who have submitted a completed application for LLP privileges. The temporary approval shall be for a period of no more than 120 days.

**ARTICLE XVI: SPECIAL LIMITED STAFF**

16.1 Membership
16.1.1 Membership on the Special Limited Staff (SLS) may be granted to selected categories of non-physician health care personnel who are employed/sponsored by a member of the medical staff and who may assist the medical staff member in specified clinical activities involving direct patient care within the hospital.
16.1.2 Appointment to the Special Limited Staff is solely at the discretion of the Board and may be terminated at will by the campus CEO or the Board.
16.1.3 Special Limited Staff members are not members of the Medical Staff and are not entitled to the rights, privileges or responsibilities of Medical Staff membership. They are subject to the provisions of these Bylaws only insofar as they specifically address them.
16.2 Categories of Members

16.2.1 Surgical assistants: A “surgeon’s assistant” is an individual who is approved to assist a surgeon in performance of an operation. The use of a surgical assistant in no way relieves the operating surgeon of his/her responsibility to have a “physician” assist when required by the medical staff Rules & Regulations. Surgical assistants may include non-licensed physician assistants, surgeon’s assistants, registered nurses, licensed practical nurses, dental assistants or dental hygienists, certified operating room technicians, orthopedic techs, genitourinary assistants, or other personnel (scrub techs) who have by training and/or experience demonstrated current competence to function as an assistant for the activities requested.

16.2.2 The Special Limited Staff may also include, but is not limited to, registered and licensed practical nurses who are approved to assist a physician with patient rounds, medical or nursing students in training, scribes, dieticians, or unlicensed medical assistants (techs), etc.

16.3 Qualifications

16.3.1 Each member of the Special Limited Staff must be employed/sponsored by a physician or oral surgeon member of the Medical Staff who will assume full responsibility for:
   a. the proper performance of all procedures assigned by him/her to the Special Limited Staff member,
   b. the proper conduct of the Special Limited Staff member within the hospital, and
   c. for their observance of the Rules & Regulations of the hospital. The responsible Medical Staff member will be required to submit a signed statement indicating that he/she accepts this responsibility.

16.3.2 In group/partnership practices, there must be one member designated as the responsible Medical Staff member. However, when this practitioner is absent for whatever reason, another member of the group/partnership must assume direction of and responsibility for the Special Limited Staff member. Nevertheless the named responsible Medical Staff member retains full responsibility for any problems, regarding conduct or performance of the Special Limited Staff member while they are in the hospital.

16.3.3 Each applicant for Special Limited Staff privileges must be qualified by training, experience and demonstrated current competence in the specific areas of clinical activity for which approval is requested. This competence must be commensurate with the qualifications required if the individual were employed by the hospital as applicable to the position commensurate with the Special Limited Staff’s scope of service.

16.3.4 The applicant must be willing and available to attend any orientation courses or special meetings required by the hospital CEO or the Credentials Committee of the Medical Staff.

16.3.5 The responsible Medical Staff member must have the Special Limited Staff member named as an insured party on their professional liability policy or the applicant must provide proof of professional liability insurance in an amount acceptable to the Board. Verification of inclusion as a named insured must be provided as part of the application and at the time of any subsequent reappointment request.

16.3.6 All Special Limited Staff members who are subject to licensure in the state of Alabama (i.e., nurses, etc.) must maintain a current license. The hospital must be notified by the responsible Medical Staff member of any failure to obtain a current license or any revocation of a license of their Special Limited Staff member.

16.4 Appointment/Reappointment

16.4.1 Application Form

The application will be provided by the Credentials Verification Office (CVO) and shall state the qualifications of, and the clinical activities/scope of service(s) requested by the applicant. The nature of the information required will be specified by the Credentials Committee but will include at least the following:
   a. Full educational summary
   b. Previous positions held, and specific experiences in the activities for which clinical scope of service(s) are being requested.
c. A signed statement authorizing the release of all information applicable to the applicant’s medical background from previously attended schools, health care institutions and/or other employers.

d. A statement, signed by the applicant, that the applicant has read the Medical Staff Bylaws, Rules & Regulations pertaining to Special Limited Staff and agrees to abide by these regulations.

e. A statement signed by the sponsoring and responsible medical staff member, that he/she has read the Medical Staff Bylaws and campus Rules & Regulations, scope of service(s), and/or job description pertaining to Special Limited Staff and agrees to abide by these regulations.

f. Evidence of malpractice coverage as a named insured on the responsible Medical Staff member’s policy or proof of professional liability insurance.

g. Current professional license verification, when applicable.

h. Specific description of clinical scope of service(s), which the responsible Medical Staff member intends the applicant to perform and evidence of the latter’s competence in performing these activities. The Medical Staff member must indicate the type and degree of supervision he/she will provide the applicant if approved.

16.4.2 Submission of Application

a. The responsible Medical Staff member must submit the application on behalf of the applicant to the Credentials Verification Office (CVO). The CVO shall, upon receipt of all the required information, submit the completed application to the appropriate campus Medical Staff coordinator(s) for review.

b. The application will be reviewed by the appropriate clinical Department Chairman for the responsible/sponsoring medical staff member’s section. A recommendation will be made to the Credentials Committee regarding approval, rejection or deferral of the application or the Department Chairman may submit revision of the requested clinical privileges based upon the training, experience and demonstrated current competence of the applicant.

c. As a Special Limited Staff member increases or improves clinical skills through additional training or experience, he or she may submit a supplementary application for privileges for additional clinical activities during the year.

16.4.3 Credentials Committee Action

a. The Credentials Committee shall make a written recommendation to approve, reject, defer or modify the application. The committee’s recommendation shall clearly delineate the scope of clinical activities approved for each applicant. This shall include a definition of the degree of supervision to be provided by the responsible medical staff member. The Credentials Committee shall submit its recommendations to the campus Medical Executive Committee for review and approval.

b. If the application is disapproved or the requested privileges significantly modified, the responsible medical staff member will be notified and he may present any additional information regarding the application for the committee’s further consideration. Following this reconsideration, the Credentials Committee shall make its recommendations as in paragraph 15.4.3(a) above.

16.4.4 Medical Executive Committee Action

a. The Medical Executive Committee shall make a written recommendation to approve, reject, defer or modify the application to the Board for review and approval.

b. If the application is disapproved or the requested privileges significantly modified, the responsible/sponsoring Medical Staff member will be notified and he/she may present any additional information regarding the application for further consideration to the Credentials Committee. Following this reconsideration, the Credentials Committee shall again make its recommendations to the Medical Executive Committee as outlined in 16.4.3 above.

16.4.5 Board Action

The recommendation of the campus Medical Executive Committee will be submitted to the Board for final action. Appointment shall be effective from the date of approval by the Board through the end of the next appointment cycle, not to exceed a two (2) year period.
16.4.6 Reappointment
a. Reappointment will be considered upon submission of a completed Reappointment Application. This form shall be furnished by the BH-CVO at the appropriate time and will include the date by which it shall be returned.
b. Recommendations for reappointment shall be made by the Credentials Committee to the campus Medical Executive Committee which reviews and makes recommendations to the Board.
c. The Board shall act upon the Medical Executive Committee’s recommendations at the next regularly scheduled meeting of the Board. Reappointment to the Special Limited Staff shall be for a period not to exceed two (2) years, concurrent with the medical staff appointment cycle.
d. An adverse recommendation for renewal of any or all clinical scope of service(s) may be appealed to the Credentials Committee and the Medical Executive Committee for a fair hearing. The decision of the Medical Executive Committee after the fair hearing is final.

16.4.7 Performance Appraisal Review
a. An evaluation of the SLS member’s competence shall be completed as follows:
   1) During initial appointment;
   2) At least every six (6) months thereafter, through the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluations (FPPE);
   3) At the time of reappointment.
b. The evaluation will be performed, at a minimum, by the following:
   1) The sponsoring physician; and,
   2) The department/unit manager most closely associated with the SLS member’s work environment (i.e.: Team Leader in OR, Neuroscience nurse manager for speech therapist, etc).

16.5 Temporary Approval
The hospital CEO may grant temporary approval to applicants who have submitted a completed application for Special Limited Staff scope of service(s). The temporary approval shall be for a period of no more than 120 days.

16.6 Limits of Activities
16.6.1 All licensed members of the special limited staff must comply with statutory and licensure regulations, if any, of the State of Alabama, regarding clinical scope of service(s).
16.6.2 No clinical scope of service(s) other than those granted by the Board may be performed by the special limited staff member.
16.6.3 Limits of clinical scope of service(s) for any specific member of the special limited staff may be prescribed by the Credentials Committee at any time, subject to approval by the Board.
16.6.4 The Credentials Committee may establish, amend and enforce Rules & Regulations for the Special Limited Staff subject to approval by the Board.

ARTICLE XVII: ALLIED HEALTH PROFESSIONALS (AHP)

17.1 Categories of Members
17.1.1 Physician Assistants: A “Physician Assistant” is an individual who is qualified by academic training and licensed by the Alabama State Board of Medical Examiners.
17.1.2 Physician Extenders: A “physician extender” is an individual with an M.D. or D.O. degree who is licensed to practice medicine in the State of Alabama, and who is employed/sponsored by a medical staff member. Functioning in the same capacity as a Physician Assistant or Nurse Practitioner, a Physician Extender does not practice independently within the hospital and delivers patient care under the oversight of the employing physician.
17.1.3 Advanced Practice Registered Nurses (APNs): this includes Nurse Practitioners and Nurse Midwives qualified by academic training, licensed by the Alabama Board of Nursing, and approved to function under a collaborative practice agreement with a physician licensed by the Alabama Board of Medical Examiners. These APNs shall be eligible for consideration of
clinical privileges only if the following criteria are met: a) the collaborating physician must be a current member of the medical staff, and b) privileges shall remain in effect only during the duration of the collaborative agreement with that medical staff member. The AHPs membership shall terminate automatically upon termination of the collaborative practice agreement or the termination of the sponsor’s medical staff membership. Nurse Anesthetists qualified by academic training and licensed by the Alabama Board of Nursing shall also be eligible for clinical privileges. A C.R.N.A. shall not practice independently within the hospital and delivers patient care under the direct oversight of the employing MDA. Nurse Practitioners, Nurse Midwives and Nurse Anesthetists shall also be required to maintain current certification in their specialty.

17.1.4 Allied Health Staff shall also include: Psychologists, Licensed Counselors, Pharm. Ds, and Podiatrists. A podiatrist is an individual with a D.P.M. degree licensed to practice podiatric medicine in the State of Alabama. Privileges granted to podiatrists shall be based on training, experience, and demonstrated competence and clinical judgment. Surgical procedures performed by podiatrists are under the overall supervision of the Chairman of the Department of Surgery. The practice of Podiatry is a scope of service offered at BMCE and PBH. Only Podiatrists who are board qualified by the American Board of Podiatric Surgery shall be eligible to apply for Allied Health membership at that facility. This group may also include occupational therapists and speech therapists who are not employed by Baptist Health or members of the medical staff, but who may render patient care or services to hospital patients pursuant to orders issued by a member of the medical staff.

17.2 Nature of Privileges
17.2.1 Allied Health Professionals may be granted privileges in their respective field of expertise. As such, they are not members of the Medical Staff and are not entitled to the rights, privileges or responsibilities of staff membership. Privileges may be withdrawn, at any time, by the Board or the hospital CEO.
17.2.2 In group/partnership practices, there must be one member designated as the responsible medical staff member. However, when this practitioner is absent for whatever reason, another member of the group/partnership must assume direction of and responsibility for the Allied Health Staff member. Nevertheless the named responsible medical staff member retains full responsibility for any problems, regarding conduct or performance of the Allied Health Staff member while they are in the hospital.

17.3 Qualifications
17.3.1 Each individual applying for privileges must be qualified by training, experience and demonstrated current competence in the specific areas of clinical activity for which clinical privileges are requested.
17.3.2 Each individual seeking clinical privileges must have a current license to practice his/her specialty in the State of Alabama and proof of appropriate malpractice insurance coverage. The hospital CEO must be immediately notified by said individual of any suspension or revocation of said license, or any challenge to said license.
17.3.3 The applicant for clinical privileges as an allied health professional must be willing and available to attend orientation courses or special meetings as called by the hospital CEO or the Credentials Committee of the medical staff.
17.3.4 The applicant must have professional liability insurance in such amount as shall be required by the Board.
17.3.5 The applicant shall in addition to the foregoing, be required to meet the qualifications set out for Medical Staff membership under Article III, Sections 1 & 2 where applicable, and shall pay an initial application fee and dues.

17.4 Appointment & Granting of Privileges
Allied health professionals will be granted clinical privileges pursuant to guidelines set by the hospital CEO and the Credentials Committee and campus Medical Executive Committees. They will be approved and appointed by the Board. Appointment shall be effective from the date of approval by the Board through the end of the next appointment cycle, not to exceed two (2) years.
17.5 **Temporary Approval**
The hospital CEO or his designee may grant temporary approval to applicants who have submitted a completed application. The temporary approval shall be for a period of no more than 120 days.

17.6 **Limits of Activities**
17.6.1 All Allied Health Professionals must comply with statutory and licensure regulations of the State of Alabama, regarding clinical privileges.
17.6.2 No clinical privileges other than those granted by the Board may be performed by any Allied Health Professional.
17.6.3 Limits on clinical activities for any Allied Health Professional may be prescribed by the campus Medical Executive Committee at any time, subject to approval by the Board.
17.6.4 The Credentials Committee may establish, amend and enforce Rules & Regulations for Allied Health Professionals subject to approval by the campus Medical Executive Committee and the Board.
17.6.5 Allied Health Professionals may not take on-call responsibilities (or on-call telephone calls) from the hospital, or make rounds for the medical staff member when the latter is off duty, out of town, or unavailable.
17.6.6 Written orders may only be given as allowed by licensure, clinical privileges and/or by the sponsoring medical staff member who must countersign same within 24 hours.

17.7 **Appointment & Reappointment**
17.7.1 **Application Form**
The application will be provided by the BH Credentials Verification Office and shall state the qualifications of, and the clinical privileges requested by the applicant. The nature of the information required will be specified by the Credentials Committee but will include at least the following:
   a. Full educational summary.
   b. Previous positions held, and specific experiences in the activities for which clinical privileges are being requested.
   c. A signed statement authorizing the release of all information applicable to the applicant’s medical background from previously attended schools, health care institutions and/or other employers.
   d. A statement signed by the applicant, that the applicant has read the Medical Staff Bylaws and campus Rules & Regulations pertaining to AHPs and agrees to abide by these regulations.
   e. A statement signed by the sponsoring and responsible medical staff member, that he/she has read the Medical Staff Bylaws and campus Rules & Regulations pertaining to AHPs and agrees to abide by these regulations.
   f. Evidence of malpractice coverage or proof of professional liability insurance.
   g. Current professional license verification.
   h. Specific description of clinical privileges the responsible medical staff member intends the applicant to perform and evidence of the latter’s competence in performing these activities.

17.7.2 **Submission of Application**
   a. The applicant will submit a completed application to the Baptist Health Credentials Verification Office. The BH-CVO shall, upon receipt of all the required information, submit the completed application to the appropriate campus medical staff coordinator(s) for review.
   b. The application will be reviewed by the appropriate clinical department chairman for the responsible/sponsoring medical staff member’s section. A recommendation will be made to the Credentials Committee regarding approval; rejection or deferral of the application or revision of the requested clinical privileges based upon the training, experience and demonstrated current competence of the applicant.
   c. As an AHP increases or improves clinical skills through additional training or experience, he or she may submit a supplementary application for additional clinical privileges.

17.7.3 **Credentials Committee Action**
a. The Credentials Committee shall make a written recommendation to approve, reject, defer or modify the application. The committee’s recommendation shall clearly delineate the scope of clinical activities approved for each applicant. This shall include a definition of the degree of supervision to be provided by the responsible medical staff member. The Credentials Committee shall submit its recommendations to the campus Medical Executive Committee for review and approval.

b. If the application is disapproved or the requested privileges significantly modified, the responsible medical staff member will be notified and he may present any additional information regarding the application for the committee’s further consideration. Following this reconsideration, the Credentials Committee shall make its recommendations as in paragraph ‘a’ above.

17.7.4 Medical Executive Committee Action
a. The Medical Executive Committee shall make a written recommendation to approve, reject, defer or modify the application to the Board for review and approval.

b. If the application is disapproved or the requested privileges significantly modified, the responsible/ sponsoring medical staff member will be notified and he/she may present any additional information regarding the application for further consideration to the Credentials Committee. Following this reconsideration, the Credentials Committee shall again make its recommendations to the Medical Executive Committee as outlined in Section 17.7.3 above.

17.7.5 Board Action
The recommendation of the campus Medical Executive Committee will be submitted to the Board for final action. Appointment shall be effective from the date of approval by the Board through the end of the next appointment cycle.

17.7.6 Reappointment
a) Reappointment will be considered upon submission of a completed reappointment form by the responsible AHP member. This form shall be furnished by the BH-CVO at the appropriate time and will include the date by which it shall be returned.

b) Recommendations for reappointment shall be made by the Credentials Committee to the campus Medical Executive Committee which reviews and makes recommendations to the Board.

c) The Board shall act upon the Medical Executive Committee’s recommendations at the next regularly scheduled meeting of the Board. Reappointment to the Allied Health Staff shall be for two (2) years, concurrent with the medical staff appointment cycle.

d) An adverse recommendation for renewal of any or all clinical privileges may be appealed to the Credentials Committee and the Medical Executive Committee for a fair hearing. The decision of the campus Medical Executive Committee after the fair hearing is final.

17.7.7 Performance Appraisal Review
a) AHP members’ competence shall be evaluated as follows:
   1) During initial appointment;
   2) At least every six (6) months thereafter, through the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluations (FPPE)
   3) At the time of reappointment.

b) For AHP’s, the evaluation will be performed, at a minimum, by the following:
   1) The sponsoring physician; and,
   2) The department/unit manager most closely associated with the AHP member’s work environment (i.e.: Team Leader in OR, Neuroscience nurse manager for speech therapist, etc).

ARTICLE XVIII: HOSPITAL BASED PHYSICIANS

18.1 Exclusive Contracts For Provision of Hospitalist, Intensivist, Radiology, Anesthesia, Pathology and Emergency Medicine Services
The Board shall have the right to enter into exclusive contracts for the provision of Hospitalist, Intensivist, Radiology, Anesthesia, Pathology and Emergency Medicine Services, as it shall deem proper. Such contracts may have provisions that link Medical Staff privileges/membership to the exclusive contract for services. As a result, privileges/membership may be reduced/terminated in the
event of a decision to transfer an existing exclusive contract at the end of its term or due to termination for cause. A termination for cause and material breach during the contract term shall be accomplished only after consultation with and with the concurrent agreement of the campus Medical Executive Committee. The execution of a new exclusive contract, or modification of an existing contract, shall be accomplished only after consultation and concurrent agreement with the affected campus Medical Executive Committee(s). Any physician entering into an exclusive contract must complete the required credentialing process as previously stated. The Medical Executive Committee shall have the right to review all non-financial portions of the exclusive contracts to ensure that no conflict(s) exist with the Medical Staff Bylaws and patient care.

18.2 Exclusivity Contracts
18.2.1 These groups shall have the right to bill for their services.  
18.2.2 Payors shall have the right to contract with specific members to provide services to their enrollees. In the case of global fee contracts awarded to the hospital, the hospital may contract with such of its members as shall accept the global fee arrangement. Members who decline to accept/participate shall have no further or future recourse as regards their decision. Any member, in good standing, who is otherwise qualified and able to provide services but who was not provided an opportunity to participate, at the time of the original offering, shall have a right to a hearing pursuant to the provisions of Article 7.2.4 et al of the Medical Staff Bylaws, except that the hearing shall be limited to the following issues:
   a. whether the member has appropriate notice and opportunity to accept the original offer to participate.
   b. whether the terms of the original contract would allow subsequent additions of providers and/or whether the original contract terms limited the number of providers that could participate.
   c. whether the member, if allowed to participate, would accept the financial terms offered and abide by the plan’s quality assurance and utilization review standards as set forth in same and was able to provide the specific services contracted for.
18.2.3 Except as specified in this Section, a decision to exclude a member shall not be subject to further appeal rights as set forth in Article 7 of the Medical Staff Bylaws.
18.2.4 At no time shall the exclusivity of a contract to provide services as set forth in Article 7 result in or bring about the closure of a staff department or the forfeiture/termination of a non-participating party’s Medical Staff membership or privileges.

18.3 The loss of privileges or staff membership: pursuant to Articles 18.1 or 18.2 shall not be reportable to the National Practitioner Data Bank (NPDB) unless specifically required by the Rules & Regulations associated with the NPDB.

ARTICLE XIX: Rules and Regulations

19.1 The Rules and Regulations of each hospital campus shall be campus specific. The Medical Staff develops the Medical Staff Rules and Regulations. The power to recommend the establishment, amendment, repeal, or enforcement mechanisms for the Rules and Regulations is vested in the campus Medical Executive Committees. That recommendation is then presented to the Active Medical Staff for vote. If approved, the recommendation is then sent to the Governing Board. If approved by the Governing Board, the recommended Rule and Regulation then becomes effective. If disapproved by the Governing Board, the recommendation goes back to the campus Medical Executive Committee for negotiation with the Governing Board on an acceptable alternative.

19.2 A recommendation by the Medical Executive Committee for a change to the Rules and Regulations will be submitted to the Active Medical Staff for review. Each Medical Staff department/section shall have an opportunity to review the recommended changes prior to voting. If changes are proposed, they shall be submitted to the Medical Executive Committee for approval. A ballot to accept or reject the recommendation shall then be distributed to the Active Medical Staff. There may also be alternative voting methodologies established for ease of voting. The Active Medical Staff will have forty five (45) days from the date of distribution of the ballot to submit their vote on same. A two-
thirds (2/3) vote of at least forty percent (40%) of the Active Medical Staff will be necessary to approve a recommendation.

19.3 Any member of the Active Medical Staff may submit recommendations to the Medical Executive Committee for changes/additions to the Rules and Regulations. Should the Medical Executive Committee decline to present the recommendations, as presented, to the Active Medical Staff for a vote, then the proponents of the proposed recommendation may take their recommendation to the Governing Board in accordance with the Governing Board’s process for such submittals. No proposed recommendation may be taken to the Governing Board unless and until it has been first submitted to the Medical Executive Committee and that Committee has declined to act/endorse such recommendation. The Medical Executive Committee shall have sixty (60) days to act on a proposed recommendation sent to it.

19.4 Any recommendation for changes/additions to the Rules and Regulations must be approved by both the Active Medical Staff and by the Governing Board before it becomes effective. Upon receipt, the Governing Board has sixty (60) days to act on a recommendation.

19.5 In the event of changes to Federal or State regulations/statutes or accreditation standards or any other regulatory mandates that would immediately impact patient safety or quality, the Medical Executive Committee and the Governing Board may provisionally approve any urgent amendments to the Rules and Regulations. The Medical Executive Committee will notify the Active Medical Staff as soon as possible following said change. If the Active Medical Staff approves the changes, the provisional approval stands. If the Active Medical Staff does not approve, the Conflict Resolution Process is implemented.

19.6 Neither the Active Medical Staff nor the Governing Board may unilaterally amend the Medical Staff Rules and Regulations. Notwithstanding the foregoing, neither the Active Medical Staff nor the Governing Board may refuse/decline to implement changes to the Rules and Regulations mandated by the State or Federal laws or regulations.

19.7 The Governing Board upholds Medical Staff Rules and Regulations that have been approved by the Governing Board.

ARTICLE XX: BYLAW CHANGES

20.1 Amendments

20.1.1 The Medical Staff develops the Medical Staff Bylaws. All proposed amendments to these Bylaws must be referred to the campus Bylaws Committees for review. Any Bylaw amendment recommended by a campus Bylaw Committee would be submitted to the Joint Bylaws Committee for consideration. Any recommendation approved by the Joint Bylaws Committee would then be submitted to each campus Medical Executive Committee for their review and subsequent approval or disapproval. If approved by both campus Medical Executive Committees, the recommendation would be published to the active Medical Staff for a vote to approve or disapprove. If one campus Medical Executive Committee votes to approve, and the other to disapprove, then the recommendation goes to the Physician Council for review and to offer/suggest compromises or changes to make the recommendation more acceptable to both parties.

20.1.2 A recommendation approved by all campus Medical Executive Committees shall be published to the Active Medical Staff at each hospital facility. Each Medical Staff department/section shall have an opportunity to review the recommended changes prior to voting. A ballot to accept or reject the recommendations shall then be distributed to the Active Medical Staff. There may also be alternative voting methodologies established for ease of voting. The Active Medical Staff shall have forty five (45) days from the date of distribution of the ballot to submit their vote on same. A two-thirds (2/3) vote of at least fifty percent (50%) of the Active Medical Staff will be necessary to approve a recommendation.
20.1.3 A recommendation, approved by the Active Medical Staff of all hospitals, is then presented to the Governing Board for final approval. Once approved by the Governing Board, the recommendation is effective. Should the Governing Board disapprove a recommendation, the recommendation goes back to the Joint Bylaws Committee for negotiation with the Governing Board on an acceptable alternative. Upon receipt of an approved recommendation, the Governing Board has sixty (60) days to act on the proposed recommendation.

20.1.4 In the event of changes to Federal or State regulations/statutes or accreditation standards or any regulatory mandates that would immediately impact patient safety or quality, both campus Medical Executive Committees and the Governing Board may provisionally approve any urgent amendments to the Bylaws. All campus Medical Executive Committees will notify all Active Medical Staffs as soon as possible following said change. If the Active Medical Staffs vote to approve the changes, the provisional approval stands. If the Active Medical Staffs do not vote to approve, the Conflict Resolution Process is implemented.

20.1.5 Neither the Active Medical Staffs nor the Governing Board may unilaterally amend the Medical Staff Bylaws. Notwithstanding the foregoing, neither the Active Medical Staff nor the Governing Board may refuse/decline to implement changes to the Bylaws mandated by State or Federal laws or regulations.

20.1.6 The Governing Board upholds Medical Staff Bylaws that have been approved by the Governing Board.

20.2 Amend
Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws.

20.3 Review
The Joint Bylaws Committee at each campus shall review these Bylaws at least annually. At the time of review, any changes or additions suggested or requested or noted to be necessary shall be reviewed. Any formal recommendation for change made by a campus Bylaw Committee shall follow the amendment guidelines outlined above in sections 20.1 and 20.2.

20.4 Change in hospital ownership: These Bylaws and the clinical privileges accorded under these Bylaws will be binding upon the hospital and Medical Staff of any successor in interest in the hospital(s).

20.5.1 The Medical Executive Committee may review the corporate Bylaws and Rules & Regulations annually to determine conflicts with the Medical Staff Bylaws. If any changes by the Board are made in the corporate Bylaws, the Board will notify the Medical Staff in writing of these changes, as well as any impending changes, and the potential impact it would have on the Medical Staff.
BYLAWS CHANGES (Need to Add PBH)

If after considerable review and discussion, proposed changes or additions lack consensus, the Physician Council will be called to assist the campus Medical Executive Committees in reaching consensus on issues that affect both campus Medical Staffs.
ARTICLE XXI: Medical Staff Credentialing Policies

21.1 The Medical Staff develops medical staff policies. The Administrative Staff shall adopt such policies and procedures as may be necessary to implement more specifically the general principles found within these Bylaws, subject to approval by the campus Medical Executive Committees and the Governing Board. These shall relate to the administrative procedures, associated with processes described within the Bylaws of corrective actions, fair hearing and appeal, credentialing, privileging, and appointment. The power to recommend the establishment, amendment, repeal, or enforcement mechanisms for the policies and procedures is vested in the campus Medical Executive Committees. The staff of the System Credentials Verification Office and the campus Medical Affairs Offices shall adhere to these policies and procedures. Such policies and procedures may be amended or repealed after submission of the proposed change to the campus Medical Executive Committees and the Governing Board. If approved by the campus Medical Executive Committees, they shall be forwarded to the Governing Board and become effective when approved by the Governing Board. When a policy is adopted or amended, it shall be communicated to the Medical Staff.

21.2 The Active Medical Staff may submit recommendations to the respective campus Medical Executive Committee for changes/additions to policies. Should the Medical Executive Committee decline to present the recommendations, as presented, to the Active Medical Staff for a vote, then the proponents of the proposed recommendation may take their recommendation to the Governing Board in accordance with the Governing Board’s process for such submittals. No proposed recommendation may be taken to the Governing Board unless or until it has been first submitted to the campus Medical Executive Committee and that Committee has declined to act/endorse such recommendation. The Medical Executive Committee shall have sixty (60) days to act on a proposed recommendation sent to it.

21.3 The Governing Board upholds Medical Staff policies that have been approved by the Governing Board.

ARTICLE XXII: Conflict Resolution

22.1 The purpose of this section is to define a process to effectively manage conflict among the organized medical staff and the campus Medical Executive Committees, and to foster cohesiveness between the groups. Conflict can be successfully managed without being resolved. The goal of this defined process is to develop a conflict management process so that conflict does not adversely affect patient safety or quality of care.

22.2 Conflict that is not managed effectively can potentially threaten health care safety and quality. The medical staffs need to manage such conflict so that health care safety and quality are protected. Foundational principles necessary to support conflict management include:

A. A willingness to acknowledge existence of conflict;
B. Open communication;
C. Dealing with conflict within an environment of mutual respect;
D. Acceptance and tolerance of different perspectives through the process;
E. Commitment to fundamental fairness;
F. Developing a conflict management process with input from the organized medical staff and medical staff leadership; and
G. Holding medical staff members accountable to use the conflict management process

22.3 The conflict management process will be implemented by any member of the organized medical staff, medical staff leadership, or governing body when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.

22.4 The conflict management process includes the following:
A. Meeting with the involved parties as soon as possible to identify the conflict. The different perspectives shall be shared in an environment of respect.
B. An individual or group will be designated to gather information regarding the conflict.

C. If informal methods of conflict management have failed to resolve the conflict, a more formal process conducted by an experienced, skilled mediator may be appropriate to manage more complex conflicts. To facilitate the management of the conflict, the corporate legal department will prepare a list of 3 trained mediators from which the involved parties will select a mediator.

D. Each group with conflict will select a representative to present their case to the mediator. The mediator will work with the representatives to successfully manage, and when possible, resolve the conflict. Findings of the mediation will be reported back to the corporate legal department for forwarding to the organized medical staff and MEC.

**ARTICLE XXIII: Conflict of Interest**

It is the policy of the Medical Staff that no member of the Medical Staff, including Medical Staff Officers and Department Chairs/Vice Chairs, should use his or her position or any knowledge gained as a result of his or her position, in any manner such that a conflict of interest does or may arise between the member and the hospital or between the member and one or more members of the Medical Staff.

Medical staff members, officers and department chair/vice chairpersons are required to disclose any interest or situation which may produce a conflict of interest, including but not limited to any outside financial or commercial interest which does or may conflict with, or give the impression of conflicting with, their decisions or vote on matters related to interactions with the hospital and/or other members of the Medical Staff.

The interest of a member of the immediate family, or of a trust, estate, company, or other enterprise of physician or of such a family member, will be considered to be the same as the interest of the physician involved.

If a physician discloses a conflict of interest, he/she shall excuse/recuse themselves from the process or discussion of the subject in question and from any vote on the question or involvement in the decision making process.

Should a physician fail to disclose a conflict of interest in a process or subject regarding medical staff or hospital issues, and is discovered during or after the process, the matter will be referred to the Medical Executive Committee for appropriate action and in keeping with their processes under these Bylaws.