



Cape Coral Hospital

Medical Staff Bylaws

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PART 1: GOVERNANCE

SECTION 1 MEDICAL STAFF PURPOSES & AUTHORITY

1.1 Purposes

The purposes of the Medical Staffs of Lee Memorial Health System are to:

- 1.1.1 Serve as the formal organizational structure of those practitioners granted the privilege of practicing in the hospitals and other facilities of the System.
- 1.1.2 Serve as the primary means for accountability to the Board for the professional performance, the quality of medical care provided to patients, and ethical conduct of its members. The Board shall have the ultimate responsibility for the quality of medical care provided to patients and the ultimate authority to approve the granting of privileges, to make appointments and reappointments to membership on the Medical Staffs, and to approve the adoption of Medical Staff Bylaws and Rules and Regulations. Such authority will be exercised based on the standard set forth in Section 1.2.
- 1.1.3 Provide a means through which members of the Medical Staffs may address with the Board those aspects of policy that involve professional practice or may affect the care of patients.

1.2 Authority

The Medical Staffs of Lee Memorial Health System are authorized by the Lee Memorial Health System Board of Directors (“the Board”) to exercise such power as is necessary to discharge its responsibilities under these Bylaws consistent with the Bylaws of Lee Memorial Health System. Lee Memorial Health System (“the System” or “the Health System”) includes acute care facilities known as Cape Coral Hospital, Gulf Coast Medical Center, HealthPark Medical Center, Lee Memorial Hospital, and The Children’s Hospital (individually known as “the hospital” and collectively known as “the hospitals”).

The Board recognizes that a well-organized, self-governing Medical Staff that provides oversight of care, treatment, and services provided by practitioners with privileges is in the best interest of patients. When acting with respect to matters of the Medical Staff, the Board shall at all times comply with the Medical Staff Bylaws, the Rules and Regulations of the Medical Staff, and applicable law.

1.3 Medical Staff

The term “Medical Staff” as used herein shall mean, on a collective basis, those practitioners who are authorized by the Board to exercise privileges at one or more of the System’s hospitals, and, on a component basis, those practitioners who are authorized by the Board to exercise privileges at a particular system hospital. The latter may be referred to herein as the “Medical Staff of a facility.” The term “he”, “him”, or “his” means of a male or female gender.

SECTION 2 MEDICAL STAFF MEMBERSHIP

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, podiatrists and/or psychologists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and the hospitals. Medical Staff membership is a privilege and not a right of any practitioner or other person. Medical Staff membership and the exercise of privileges in connection therewith shall be extended only to practitioners who continuously meet the requirements of these Bylaws. The Board makes decisions regarding Medical Staff matters, based on Medical Staff recommendations, in accordance with these Bylaws. Membership on the Medical Staff shall confer on the Medical Staff member only such rights as set forth in the Bylaws. No person shall admit patients to a System hospital unless he is appointed to the Medical Staff of such hospital. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" the Medical Staff. Medical Staff members granted membership and privileges at a hospital, which has services and facilities that are provider based to a main provider and are authorized to exercise those privileges at the main provider.

2.2 Qualifications for Membership

2.2.1 The qualifications for Medical Staff membership are delineated in Part III of these Bylaws (Credentials Procedures).

2.3 Nondiscrimination

2.3.1 No Automatic Entitlement

No person shall be automatically entitled to Medical Staff membership or to the exercise of clinical privileges merely because he is licensed to practice, is a member of any professional organization, is certified by any board, or had held (but not currently) Medical Staff membership or clinical privileges at a System hospital or at any other health care facility. The burden shall be on the applicant to establish his qualifications. Acceptance of Medical Staff membership or exercise of clinical privileges shall constitute an agreement to strictly abide by these Bylaws, the applicable Medical Staff Policies, the Rules and Regulations, and the Principles of Medical Ethics set forth in Appendix A hereof and all other appropriate ethical standards governing the practitioner's practice. No person shall be initially appointed to the Medical Staff or granted clinical privileges if the hospitals are unable to provide adequate facilities and supportive services for the applicant and his patients. Medical Staff membership shall not be denied based on sex, race, creed, color, national origin or economic credentialing, at initial appointment or reappointment.

2.4 Conditions and Duration of Appointment

2.4.1 The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Facility Medical Executive Committee (FMEC). Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

2.5.1 Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria recommended by the System Credentialing/Privileging Committee and FMEC and approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures) of these Bylaws, including but not limited to, Part III, Sections 3 and 11.3 regarding Contracted practitioners.

2.6 Medical Staff Members' Responsibilities

2.6.1 Duties of Appointees

Appointment to the Medical Staff shall require that each practitioner assume such reasonable duties and responsibilities, as the Medical Staff shall require.

2.7 Basic Responsibilities of Applicants and Appointees

The following basic responsibilities and requirements shall be applicable to every applicant and appointee for Medical Staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

- 2.7.1 an obligation to provide for appropriate and timely care and supervision to all patients in the hospital for whom the individual has responsibility (Standard of Care);
- 2.7.2 an agreement to abide by all Bylaws, Rules and Regulations and Policies of the Medical Staff and the Hospital, as shall be in force during the time the individual is appointed to the Medical Staff (Conformance to Rules);
- 2.7.3 an agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned (Committee Assignments);
- 2.7.4 to not participate in illegal fee splitting or other illegal inducements relating to patient referral;
- 2.7.5 to promptly notify Medical Staff Services (Notification Requirements);
 - 2.7.5.1 if his professional license in any state is suspended or revoked;
 - 2.7.5.2 of the imposition of any conditions by any state licensing authority on his continued ability to practice his profession, including probation or limitations on the scope of practice;
 - 2.7.5.3 of the loss or restriction of Medical Staff membership or privileges at any other health care facility;
 - 2.7.5.4 if his Drug Enforcement Agency (DEA) license number is suspended, revoked or voluntarily relinquished;

- 2.7.5.5 of any change in eligibility for participation in Federal Health Care Programs including any sanctions imposed or recommended by the Federal Department of Health and Human Services, Florida State Agency for Health Care Administration and/or the receipt of any citation and/or quality denial letter concerning alleged quality problems in patient care;
 - 2.7.5.6 if the practitioner enters, participates in, or against medical advice, leaves or refuses any program of treatment prescribed or required by the Florida Physicians' Recovery Network;
 - 2.7.5.7 if the practitioner is admitted for, seeks, or is undergoing treatment for substance or alcohol abuse or a behavioral health problem. "Substance abuse" shall include but not limited to, use or ingestion of illegal drugs, or use or ingestion of prescription medications not prescribed in the ordinary course of treatment of injury or disease. "Behavioral health problem" shall mean any condition or disease of a psychiatric or psychological nature which, in the opinion of a qualified psychiatrist, adversely affects the practitioner's ability to care for patients or practice his profession in accordance with the applicable prevailing standard of care; or
 - 2.7.5.8 the conviction of, or pleading of nolo contendere to, a crime constituting a felony in any jurisdiction.
- 2.7.6 to abide by generally recognized ethical principles applicable to the applicant's or appointee's profession and by the code of ethics set forth in Appendix A (Ethics);
 - 2.7.7 to respect the confidentiality of all information obtained in connection with his responsibility as a Medical Staff member and comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Confidentiality);
 - 2.7.8 to provide medical consultation in a timely fashion in accordance with all applicable Rules & Regulations and Medical Staff Policies (Consultation);
 - 2.7.9 to participate in the monitoring and evaluation activities of Clinical Sections and cooperate with other members of the Medical Staff and the System, in programs designed to improve the quality of care to reduce or eliminate waste in the use of scarce System resources and to reduce the risk of injury to patients and others in the provision of care (Quality Review Participation);
 - 2.7.10 to complete in a timely and legible manner the medical records and other required records for all patients as required by these Bylaws, applicable Rules and Regulations, and other applicable policies of the hospital (Medical Records);
 - 2.7.11 to pay promptly any applicable Medical Staff assessments and dues (Dues);
 - 2.7.12 to participate in continuing education programs for the benefit of the applicant or appointee and for the benefit of other professionals and System hospital personnel (CME);
 - 2.7.13 to authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or clinical privileges (Release of Information);

- 2.7.14 to submit to an evaluation of his physical and/or mental health status by a physician or physicians acceptable to the FMEC or Board, whenever the FMEC or Board has reason to question the physical and/or mental health status of the practitioner, as a prerequisite to further consideration of his application for appointment or reappointment, the exercise of previously granted privileges or maintenance of his Medical Staff appointment (Physical/Mental Exam);
- 2.7.15 to recognize the obligations established to fulfill the hospital's responsibilities under the Emergency Medical Treatment and Women in Labor Act (EMTALA), the Access to Emergency Services and Care Act and/or other applicable regulations, requirements or standards and to share in the responsibility for providing physician coverage on an emergency basis in the Emergency Department, in accordance with the provisions of the Medical Staff Bylaws and all applicable facility-specific Rules & Regulations and Medical Staff Policies (On Call Coverage);
- 2.7.16 to provide his professional services to hospitalized or emergency room patients covered by Medicaid and similar programs of indigent care, or such patients without personal physicians or insurance coverage, in accordance with Medical Staff Rules & Regulations adopted by the FMEC delineating the responsibility to provide services to those patients (Services to Indigent Patient);
- 2.7.17 provide proof of financial responsibility to pay claims or costs associated with the rendering of, or failure to render, medical care or services in compliance with Florida law governing the practitioner's license to practice in the State of Florida. Proof of financial responsibility shall be provided at the time of initial appointment and on reappointment, at the time the practitioner changes the method of meeting his financial responsibility and at any other time on the request of Medical Staff Services (Financial Responsibility);
- 2.7.18 to behave in a professional and civil manner and conduct himself in a manner conducive to excellent patient care and to work cooperatively with Medical Staff appointees, and with other health care professionals, and Hospital personnel, so as not to adversely affect patient care. This requirement is not in any way intended to interfere with a practitioner's right: (1) to express opinions freely and to support positions whether or not they are in dispute with those of other Medical Staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment; or (3) to engage in a good faith criticism of others. The following types of behavior, however, which constitute some examples of an inability to interact on a professional basis with others or to behave in a professional and civil manner, are deemed unacceptable for a member of the Medical Staff:
 - 2.7.18.1 conduct that reasonably could be characterized as sexual and/or racial harassment;
 - 2.7.18.2 threats of physical assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;
 - 2.7.18.3 the unnecessary, unwarranted and unjustifiable knowing use of loud, profane or abusive language directed toward members of the Medical Staff, patient and others; or

- 2.7.18.4 written or oral statements that constitute the intentional expression of falsehoods, or constitute deliberately disparaging statements made with reckless disregard for their truth or for the reputation and feelings of others;
- 2.7.18.5 doing anything of a similar nature that the practitioner has been warned not to do by the President of the Medical Staff or FMEC Committee (Professional and Civil Behavior);
- 2.7.19 duty to give notice if the practitioner is not actively engaged in the practice of his profession in Lee County (Lack of Active Practice);
- 2.7.20 duty to give notice if practitioner does not maintain a full-time residence and office in Lee County, unless the residence and office requirements have been waived in accordance with these Bylaws (Residence or Office in Lee County).

2.8 Member Rights

The following basic rights shall apply to Medical Staff practitioners:

- 2.8.1 Each Medical Staff member, in the active category, has the right to a meeting with the FMEC and/or the Physician Leadership Council (PLC) on matters relevant to the responsibilities of the FMEC and/or the PLC, provided that the practitioner has attempted to resolve a matter of concern after working with his Department Chair or other appropriate hospital and/or Health System Medical Staff leader(s). Upon written notice to the President of the Medical Staff, two (2) weeks in advance of a regular meeting, the active Medical Staff member may meet with the FMEC and/or the PLC to discuss the issue.
- 2.8.2 Each Medical Staff member, in the active category, has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 5.7 of these Bylaws regarding removal and resignation from office.
- 2.8.3 Each Medical Staff member, in the active category, may request a special meeting of the Medical Staff, upon presentation of a petition, stating the purpose of the meeting and signed by ten (10) members of the Active Medical Staff. The FMEC shall schedule a special meeting for the specific purposes addressed by the petitioners in accordance with Section ten (10) of these Bylaws. No business other than that detailed in the petition may be transacted.
- 2.8.4 An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing/appeal pursuant to the conditions and procedures described in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).
- 2.8.5 All other rights as specified by these Bylaws.

2.9 Medical Staff Dues and Assessments

- 2.9.1 Annual Medical Staff dues, if any, shall be determined by the FMEC. Failure of a Medical Staff member to pay dues shall be considered a voluntary resignation from the Medical Staff. The FMEC may pass policies from time to time that exempt certain categories of membership or members holding specified leadership positions from payment of dues. The FMEC shall authorize the use of Medical Staff dues.

- 2.9.2 Medical Staff System-wide assessments, such as a library assessment, shall be determined by the PLC, on behalf of the FMECs. Failure of a Medical Staff member to pay any assessment(s) shall be considered a voluntary resignation from the Medical Staff. The PLC, on behalf of the FMECs, may pass policies from time to time that exempt certain categories of membership or members holding specific leadership positions from payment of such assessment(s).
- 2.9.3 The PLC, on behalf of the FMECs, shall authorize the use of Medical Staff assessments consistent with the purpose of the assessment.

2.10 Conflict of Interest

- 2.10.1 In any instance where an officer, committee Chair, or member of any Medical Staff committee has, or reasonably could be perceived to have a conflict of interest, or to be biased in any matter involving another Medical Staff appointee or any other matter that comes before such individual or committee, or in any instance where any such individual brought the complaint against that practitioner, such individual shall not participate in the discussion or voting on the matter and shall be excused from any meeting during that time, although that individual may be asked and may answer, any questions concerning the matter before leaving. As a matter of procedure, the Chair of that committee designated to review the matter shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the Chair by any committee member with knowledge of the matter.
- 2.10.2 In any instance where an officer, committee Chair, or member of any Medical Staff committee has a conflict of interest in any matter that comes before such individual or committee, such individual has the right to abstain or recuse himself from voting on such matter. Such abstention or recusal shall not prohibit such individual from providing factual information or participating in discussion on such matter. If an individual is requested to abstain or recuse himself and refuses to do so, the potential conflict of interest issue will be reviewed and resolved by the next highest authority as outlined in these Bylaws. As a matter of procedure, the Chair of that committee designated to review the matter shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the Chair by any committee member with knowledge of the matter.
- 2.10.3 Assurance of a conflict of interest or bias can be determined by a majority vote of the members of the committee where a quorum is present.

SECTION 3 CONFIDENTIALITY, IMMUNITY AND RELEASES

3.1 Confidentiality

Information with respect to any practitioner or regarding any other subject discussed, submitted, collected or prepared by any representative of the Lee Memorial Health System, including officers or members of organized committees of the Health System's Medical Staffs, or any other healthcare professional, healthcare facility, organization or Medical Staff, for the purpose of achieving and maintaining the quality of care, reducing morbidity or mortality or contributing to clinical research shall, in accordance with Florida law,

be confidential and shall not be disseminated or used for any purpose other than the foregoing. Such information shall not be deemed a part of the patient medical record, and shall not be filed therein. Each individual or committee member participating in such activities shall agree to make no disclosures of any such information except as authorized, in writing, by the Chief Executive Officer (CEO) or by legal counsel to the hospitals.

Any breach of confidentiality by an individual or committee member may result in a professional review action, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

3.2 Immunity

- 3.2.1 Any Medical Staff officer, Department Chair, Section Chief, committee Chair, committee member, and individual staff appointee who acts in good faith for and on behalf of any System hospital in discharging duties, functions or responsibilities stated in these Medical Staff Bylaws, applicable Policies, and/or Rules and Regulations shall be afforded protection by the Board of Directors to the fullest extent permitted by law in accordance with written policies adopted by the Board. Individuals and organizations independent of the Medical Staff or any of its members who may be engaged by the Health System to perform the review, analysis and evaluation of the qualification and/or performance of practitioners with membership and/or privileges on the Medical Staff are afforded protection by the Board of Directors in accordance with written policies adopted by the Board, provided such individuals or organizations act in good faith.
- 3.2.2 To the fullest extent permitted by law, each applicant and appointee to the Medical Staff releases from any and all liability, and extends absolute immunity to System hospitals and the Board and its individual members, and to the System's authorized representatives and agents, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:
- 3.2.2.1 applications for appointment or clinical privileges, including temporary privileges and/or emergency privileges;
 - 3.2.2.2 evaluations concerning reappointment or changes in clinical privileges;
 - 3.2.2.3 proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
 - 3.2.2.4 summary suspension;
 - 3.2.2.5 hearings and appellate reviews;
 - 3.2.2.6 medical/surgical care evaluations;
 - 3.2.2.7 utilization reviews;
 - 3.2.2.8 other activities relating to the quality of patient care or professional conduct;
 - 3.2.2.9 matters of inquiries concerning the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and/or

3.2.2.10 any other matter that directly or indirectly might relate to the applicants or appointee's competence, and/or to patient care.

3.3 Releases

3.3.1 Authorization to Obtain Information

The applicant or appointee specifically authorizes the Medical Staff and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's or appointee's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect, or obtain all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the Medical Staff and its authorized representatives upon request.

3.3.2 Legal Effect

The confidentiality provisions and protections described in this Section shall not limit or supersede any protection or immunity afforded by law.

SECTION 4 CATEGORIES OF THE MEDICAL STAFF

4.1 Active Category

4.1.1 Qualifications: Members of this category must have served on the Medical Staff, maintained a residence and office in Lee County (4.1.3.3) for one year, and be involved in twenty-four (24) patient contacts per year (i.e., a patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient surgical procedure) at the hospital except as expressly waived for practitioners with at least twenty (20) years of service in the active category or for those physicians who document their efforts to support the hospital's patient care mission to the satisfaction of the FMEC.

In the event that a member of the active category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all Bylaws, Rules and Regulations, and policies of the Medical Staff and hospital, the member may be appointed to another Medical Staff category if he meets the eligibility requirements for such category.

4.1.2 Prerogatives: Members of this category may:

4.1.2.1 Attend Medical Staff/Department meetings of which he is a member and any Medical Staff or hospital education programs;

4.1.2.2 Vote on all matters presented by the Medical Staff, Department, and committee(s) to which the member is assigned;

4.1.2.3 Hold office and sit on or be the Chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

4.1.3 Responsibilities: Members of this category shall:

4.1.3.1 Contribute to the organizational and administrative affairs of the Medical Staff;

4.1.3.2 Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities and in the discharge of other Medical Staff functions as may be required by the FMEC;

4.1.3.3 The one-year residence and office requirement may be explicitly waived by majority vote of the FMEC, on written request of the practitioner, at the time of appointment, if the practitioner affirmatively demonstrates to the FMEC in writing that the quality of patient care is not likely to be affected by his not living and having an office in Lee County and that the practitioner's obligation to provide emergency room call and to attend hospitalized patient can be met.

4.1.3.4 Fulfill or comply with any applicable Medical Staff or hospital policies or procedures as requested by the FMEC.

4.1.3.5 Fulfill basic responsibilities and requirements set forth in Section 2.7 of this Part, including but not limited to, Emergency Department call responsibilities in accordance with facility specific rules and regulations, unless exempted from Emergency Department call responsibilities as defined by their Section (if applicable) or Department and approved by the FMEC.

In the event facility specific rules and regulations require physicians to accept emergency department referrals to the physician's office, Lee Memorial Health System will provide facility support and services for such patients.

4.2 Associate Category

4.2.1 Qualifications: The associate category is reserved for Medical Staff members who do not meet the eligibility requirements for the active category or choose not to pursue active status. This category includes physicians during their first year on the Medical Staff, as well as low volume/no volume physicians.

4.2.2 Prerogatives: Members of this category may:

4.2.2.1 Attend general Medical Staff Department meetings of which he is a member and any Medical Staff or hospital education programs.

4.2.2.2 Members of the associate category may not vote on matters at general Medical Staff, Department meetings or be an officer of the Medical Staff.

4.2.2.3 Members of the associate category may serve on facility and system Medical Staff committees, other than the FMEC, and may vote on matters that come before such committees.

4.2.3 Responsibilities: Members of this category shall have the same responsibilities as active category members, as set forth in Section 4.1 and Section 2.7 of this Part.

4.3 Honorary Category

4.3.1 The Honorary category is restricted to those individuals recommended by the FMEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the honorary category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend general Medical Staff meetings, Department meetings, continuing medical education (CME) activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

SECTION 5 OFFICERS OF THE MEDICAL STAFF

5.1 Officers of the Medical Staff and FMEC at-large Members: Each hospital is authorized to have the following officers:

5.1.1 Facility President of the Medical Staff

5.1.2 Facility President-Elect of the Medical Staff

5.1.3 Facility Secretary/Treasurer

5.1.4 Facility Past President of the Medical Staff

5.2 Qualifications of Officers and FMEC at-large Members

5.2.1 Officers must be members in good standing of the active category for at least three (3) years or actively involved in patient care in the community, have previously served in a significant leadership position on a Medical Staff, (i.e. Department Chair, Section Chief or Committee Chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have a history of attendance at continuing education programs (provided by the System) relating to Medical Staff leadership and/or be willing to do so during their term or office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the Medical Staff, and should have excellent administrative and communication skills.

FMEC at large members must be members in good standing of the active category for at least two (2) years or actively involved in patient care in the community.

5.2.2 Officers and FMEC at-large members must disclose leadership positions on another hospital Medical Staff.

5.3 Election of Officers and FMEC at-large Members

5.3.1 Every year, the FMEC shall appoint a nominations committee Chaired by the immediate Past Facility President of the Medical Staff and comprised of at least

five (5) at large members of the active Medical Staff at least ninety (90) days prior to the election. Representatives of administration shall not serve on the nominations committee. Nominations will be solicited from the Medical Staff for consideration prior to the committee meeting. The committee shall offer at least one nominee for each office. Nominations must be announced, and the names of the nominees distributed to all members of the active Medical Staff at least forty-five (45) days prior to the election. A petition signed by at least 20% of the members of the active Medical Staff may also make nominations. Such petition must be submitted to the President of the Medical Staff at least twenty (20) days prior to the election for placement on the ballot.

5.3.2 Officers and FMEC at-large members shall be elected, as needed every year at an election that takes place at least one (1) month prior to the expiration of the term of the current officers. Only members of the active category shall be eligible to vote. The FMEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots; electronic voting via computer, fax, or other technology for transmitting the members' voting choices. No proxy voting will be permissible. The nominee receiving the greatest number of votes will be elected. In the event of a tie vote, the Medical Staff support professional will arrange for a repeat vote(s) until one candidate receives a greater number of votes.

5.3.3 Medical Staff members will be notified of the election date and final slate of nominees ten (10) days prior to the election.

5.4 Terms of Office

5.4.1 Officers and FMEC at-large members serve terms as follows:

5.4.1.1 Facility President-Elect of the Medical Staff – one (1) year

5.4.1.2 Facility President of the Medical Staff – two (2) years

5.4.1.3 Facility Past President of the Medical Staff – one (1) year

5.4.1.4 Facility Secretary/Treasurer – one (1) year

5.4.1.5 FMEC Members-at-Large – two (2) years

5.4.2 Officers shall take office October 1. Officers may be re-elected to office except that the Facility President of the Medical Staff may not be re-elected for successive terms.

5.5 Vacancies of Office

5.5.1 The FMEC shall fill vacancies of office during the Medical Staff year, except the office of the Facility President of the Medical Staff.

If there is a vacancy in the office of the Facility President of the Medical Staff, the Facility President-Elect of the Medical Staff shall serve the remainder of the term.

5.6 Duties of Officers and FMEC At-Large Members

5.6.1 Facility President of the Medical Staff – The Facility President shall represent the interests of the Medical Staff to the FMEC and the Board. The Facility President will fulfill the duties specified in Section 5.6.2 of these Bylaws, as well as additional duties as reasonably requested by the FMEC in order to implement and/or enforce all provisions of the Bylaws and the interests of the Medical Staff.

5.6.2 Responsibilities of the Facility President of the Medical Staff

The Facility President of the Medical Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board, the Facility Chief Administrative Officer (CAO) and the Health System administration. The Facility President of the Medical Staff, jointly with the FMEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff Bylaws, Rules and Regulations and Policies. Specific responsibilities and authority include:

- 5.6.2.1 Call and preside at all general and special meetings of the Medical Staff;
- 5.6.2.2 Serve as Chair of the FMEC, a voting member of the PLC and as ex-officio member of all other Medical Staff committees without vote, and to participate as invited by the Board and the Facility CAO on hospital or Board committees;
- 5.6.2.3 Shall not vote at the FMEC, unless their vote is needed to break a tie vote;
- 5.6.2.4 Enforce Medical Staff Bylaws, Rules and Regulations and Medical Staff/hospital/System Policies;
- 5.6.2.5 Except as stated otherwise, appoint committee Chairs and all members of Medical Staff standing and ad hoc committees; in consultation with hospital administration, appoint Medical Staff members to appropriate hospital committees, in consultation with the Chair of the Board, appoint the Medical Staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
- 5.6.2.6 Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;
- 5.6.2.7 Report to the Board, through the PLC, the FMEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services and corrective action with respect to practitioners or allied health practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;
- 5.6.2.8 With the support of the facility Credentials/Privileging Committee and the System Credentialing/Privileging Committee, evaluate and periodically report to the FMEC, PLC and the Board regarding the effectiveness of the credentialing and privileging processes;
- 5.6.2.9 Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Board, hospital/System management, other professional and support staff, and the community the hospital serves;
- 5.6.2.10 Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting hospital operations to the Facility CAO, the FMEC, PLC and the Board;

- 5.6.2.11 attends Board meetings and Board committee meetings as deemed appropriate by Facility Medical Staff President;
 - 5.6.2.12 ensures that the decisions of the Board are communicated and carried out within the Medical Staff;
 - 5.6.2.13 performs such other duties, and exercises such authority commensurate with the office as are set forth in the Medical Staff Bylaws.
- 5.6.3 Facility President-Elect of the Medical Staff – In the absence of the Facility President, the Facility President-Elect or the Facility Past President shall assume all the duties and have the authority of the Facility President. He shall perform such further duties to assist the Facility President as the Facility President may request from time to time. The Facility President-Elect, upon the end of the term of the Facility President, shall automatically succeed to the office of Facility President.
- 5.6.4 Facility Secretary/Treasurer – This officer will collaborate with the hospital's Medical Staff office, assure maintenance of minutes, attend to correspondence, act as Medical Staff treasurer, and coordinate communication within the Medical Staff. He shall perform such further duties to assist the Facility President as the Facility President may from time to time request.
- 5.6.5 Facility Past President of the Medical Staff – This officer will serve as a consultant to the Facility President and the Facility President-Elect as requested by the FMEC and provide feedback to the officers regarding their performance of assigned duties on an annual basis.
- He shall perform such further duties to assist the Facility President as the Facility President may request. He shall serve as a member of the System Credentialing/Privileging Committee.
- 5.6.6 FMEC at-large members – shall advise and support the Medical Staff officers and are responsible for representing the needs/interests of the entire Medical Staff and not simply representing the preferences of their own clinical specialty.

5.7 Removal and Resignation of Officer or FMEC At-Large Member

- 5.7.1 The Medical Staff may remove any facility officer or FMEC at-large member by petition of 20% of the active Medical Staff members and a subsequent affirmative vote by two-thirds (2/3) of those active Medical Staff members' casting votes.

- 5.7.2 Recall of Officers or FMEC at-large members

The FMEC may remove any facility Medical Staff officer or FMEC at-large member for conduct detrimental to the interests of the Medical Staff or if the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office. At least ten (10) days notice prior to the date of the meeting shall be provided, in writing, to the affected officer or FMEC at-large member. The officer or at-large member shall be afforded the opportunity to speak prior to the taking of any vote on such removal. For recall of an officer or at-large member, a two-thirds (2/3) vote of approval is required with three-fourths (3/4) of the FMEC members present and voting. Affected officer or at-large member does not count as quorum and does not vote.

5.7.3 Resignation of Officers or FMEC at-large members

Any elected officer or FMEC at-large member may resign at any time by giving written notice to the FMEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

SECTION 6 MEDICAL STAFF ORGANIZATION

The organized Medical Staff is actively involved in Medical Staff governance, peer review, credentialing/privileging and communication. Medical Staff members are accountable to the FMEC.

The Medical Staff facility officers (Section 5), Medical Staff governance committees (PLC, Section 7.1 and FMEC, Section 7.4), Department Chairs (Section 6.1), clinical Section Chiefs (Section 6.1.1), hospital (as appropriate) System Medical Staff committee Chairs, (Section 7.6) and facility Medical Staff committee Chairs (Section 7.7) are responsible for working collaboratively to develop a process for communication of Medical Staff functions. Periodic reports, as appropriate, are given to each FMEC, Medical Staff Departments, Medical Staff committees and the PLC as needed to ensure adherence to regulatory requirements and accreditation standards.

Additionally, Medical Staff officers may appoint, in collaboration with the Facility Medical Director, designated physician leaders to serve on the following Medical Staff committees to help ensure Medical Staff input and oversight with clinical functions such as System Bylaws, Cancer Care, CME/Medical Library, Ethics, Institutional Review, System Credentialing/Privileging, Critical Care, System Emergency Services, Infection Control, Pharmacy and Therapeutics, System Medical Staff Quality, System Practitioner Resource, Trauma Quality, Vascular Lab, in addition to the Children's Hospital committees (Cancer Care, Ethics, Neonatal Intensive Care Unit (NICU) Pediatric Intensive Care Unit (PICU) Perinatal and Medical Staff Quality and other such functions as determined by the FMEC and/or the PLC.

6.1 Departments

The Medical Staff shall be organized as a Departmentalized staff. The current Departments authorized by the FMECs are Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Anesthesiology, Pathology, Radiology and Emergency Medicine. Departments fulfill the duties listed in Section 6.2.4 of these Bylaws within a specific hospital or facility and/or across the Health System as necessary. Departments shall meet as frequently as needed to fulfill assigned duties and when requested by the FMEC.

The Medical Staff may create Clinical Sections (as specified in these Bylaws) within a Department in order to facilitate Medical Staff activities.

6.1.1 Any FMEC may recognize any group of like American Board of Medical Specialties, (ABMS) approved specialties with at least three (3) Medical Staff members or service lines that wish to organize themselves into a Clinical Section. Any Clinical Section, if organized shall not be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the Clinical Section is making a formal report. A Clinical Section shall elect a Clinical Section Chief.

The Clinical Section Chief is responsible for fulfilling the activities listed in Section 6.1.1.1 - 6.1.1.7 of these Bylaws. The procedure for removal of a Clinical Section Chief shall be the same as set forth in Section 6.2.3 for Department Chair.

When a clinical Section is making a formal report, the report shall be submitted to the FMEC documenting the specific position of the clinical Section. The President of the Medical Staff and the Clinical Section Chief (or designee) will decide if the report/issue is placed on the FMEC agenda and whether the Clinical Section Chief (or designee) will attend the FMEC meeting to present the report/issue to the FMEC on that specific report/issue. Clinical Sections are optional and shall exist to perform any of the following activities within a specific facility and/or across Health System facilities as necessary:

- 6.1.1.1 continuing education/Grand Rounds/discussion of patient care;
- 6.1.1.2 formulation of ED on-call and inpatient consultation and coverage recommendations;
- 6.1.1.3 discussion of policies and procedures;
- 6.1.1.4 discussion of equipment needs;
- 6.1.1.5 development of recommendations for the Department Chair(s), the FMECs or the PLC;
- 6.1.1.6 participation in the development of criteria for clinical privileges when requested by the System Credentialing/Privileging Committee or FMEC;
- 6.1.1.7 discussion of a specific issue at the request of the PLC or the FMEC.

The FMEC, with the concurrence of the PLC, may designate new Medical Staff Departments or Clinical Sections or dissolve current Departments or Clinical Sections as it determines will best meet the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

6.2 Qualifications, Selection, Term, and Removal of Department Chair

- 6.2.1 Each Department Chair shall serve a term of two (2) years commencing on October 1 and may be elected to serve successive terms.

All Chairs must be members of the active Medical Staff with relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process.

- 6.2.2 Department Chairs and Vice-Chairs will be elected by majority vote of the active members of the Department, subject to ratification by the FMEC. Each Department shall establish procedures for identifying and electing candidates and these procedures must be ratified by the FMEC.

- 6.2.3 Department Chairs may be removed from office by the FMEC upon receipt of a recommendation of two-thirds (2/3) of the members of the Department or, in the absence of such recommendation, the FMEC may remove a Chair on its own by a two-third (2/3) vote of a majority of members present and voting, if any of the following occurs:
 - 6.2.3.1 The Chair ceases to be a member in good standing of the Medical Staff;
 - 6.2.3.2 The Chair suffers an involuntary loss or significant limitation of practice privileges;
 - 6.2.3.3 The Chair fails, in the opinion of the FMEC, to demonstrate to the satisfaction of the FMEC, PLC or the Board that he is effectively carrying out the responsibilities of the position;
 - 6.2.3.4 If removal is required, a new election will be held according to the established Departmental procedures.
- 6.2.4 Department Chairs shall carry out the following responsibilities:
 - 6.2.4.1 to oversee all clinically-related activities of the Department;
 - 6.2.4.2 to oversee all administratively related activities of the Department otherwise provided for by the Facility;
 - 6.2.4.3 to provide ongoing surveillance of the performance of all individuals in the Medical Staff Department who have been granted clinical privileges;
 - 6.2.4.4 to recommend to the System Credentialing/Privileging Committee Medical Staff Department;
 - 6.2.4.5 to recommend clinical privileges for each member of the Department and other LIPs practicing with privileges within the scope of the Department;
 - 6.2.4.6 to assess and recommend to the FMEC and Facility CAO off-site sources for needed patient care services not provided by the Medical Staff Department or Facility;
 - 6.2.4.7 to monitor and evaluate the quality and appropriateness of patient care provided in the Medical Staff Department and to implement action following review and recommendations by the facility Medical Staff peer review/quality committee and/or the FMEC;
 - 6.2.4.8 to integrate the Department into the primary functions of the hospital;
 - 6.2.4.9 to coordinate and integrate interdepartmental and intradepartmental services and communication;
 - 6.2.4.10 to participate in the administration of the Department through cooperation with nursing services and hospital administration in matters affecting patient care;

- 6.2.4.11 to develop and implement Medical Staff and hospital policies and procedures that guide and support the provision of patient care services;
- 6.2.4.12 to recommend to the Facility CAO the sufficient numbers of qualified and competent persons to provide patient care and service;
- 6.2.4.13 to provide input to the Facility CAO regarding the qualifications and competence of Department or service personnel who are not Licensed Independent Practitioners (LIPs) but provide patient care, treatment, and services;
- 6.2.4.14 to provide continuous assessment and improvement of the quality of care, treatment, and services;
- 6.2.4.15 to maintain quality control programs as appropriate;
- 6.2.4.16 to orient and continuously educate all persons in the Department;
- 6.2.4.17 to make recommendations to the FMEC and to the Facility CAO for space and other resources needed by the Medical Staff Department to provide patient care services.

6.3 Assignment to Department

- 6.3.1 The FMEC will, after consideration of the recommendation of the Chair of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department. Clinical privileges are independent of the Department assignment.

SECTION 7 MEDICAL STAFF GOVERNANCE COMMITTEES

7.1 Designation of the Lee Memorial Health System Medical Staff Physician Leadership Council (PLC)

- 7.1.1 There shall be a Lee Memorial Health System Medical Staff Physician Leadership Council (PLC) and such other standing and special committees as determined by the PLC.
- 7.1.2 There shall be a Facility Medical Executive Committee (FMEC) at each hospital and such other facility standing and special committees as established by the FMEC.

7.2 Composition of the Lee Memorial Health System Medical Staff PLC

7.2.1 Composition:

The PLC shall consist of the following voting members: Each Facility President and each Facility President–Elect or each Facility Immediate Past President and two (2) at-large Medical Staff members elected by each FMEC. All shall serve a 2-year term except the Facility President-Elect and Facility Past President shall serve 1-year term. The Chairs of the System Credentialing/Privileging Committee and

System Quality Committee, the system CEO or Designee, the System Chief Medical Officer and the Chair of the Board and up to two (2) other Board consultants, shall serve as ex-officio, non-voting members. The PLC will elect the PLC Chair and a Vice Chair who shall serve a 2-year term.

In the event that the PLC composition does not include one anesthesiologist, emergency medicine physician, hospitalist or intensivist, radiologist and pathologist, the PLC may appoint an active Medical Staff member from each of these hospital-based specialties to be voting members of the PLC.

7.2.2 Duties:

The duties of the Lee Memorial Health System PLC are:

- 7.2.2.1 to work in a cooperative and professional manner with the FMECs System and Facility Administration and the Board to ensure Medical Staff input into the plans, goals and mission of the Lee Memorial Health System;
- 7.2.2.2 receive, review, and transmit FMEC recommendations to the Board;
- 7.2.2.3 review and attempt to resolve any inconsistency emanating from the FMEC recommendation(s) and transmit FMEC recommendations to the Board concerning all matters relating to appointments, reappointments, staff category, facility assignments, clinical privileges subject to the conflict resolution process herein, unless due process rights are triggered pursuant to Part II. The PLC is acting as a duly constituted peer review committee under Florida law when it is reviewing the quality of care or performance of any particular physician.
- 7.2.2.4 consistent with the hospital and Medical Staff mission and philosophy, the PLC will participate and encourage participation of the FMECs in identifying community health needs and in setting goals and work with the System administration and the facility CAO(s) to design and implement programs to meet those needs;
- 7.2.2.5 work with the FMECs to ensure understanding and the consistent application of Medical Staff Rules and Regulations, Policies and Procedures; and
- 7.2.2.6 govern the collection of Medical Staff system-wide assessments and authorize the use of Medical Staff assessments consistent with the purpose of the assessment.

7.2.3 Meetings:

The PLC shall meet as frequently as needed, but at least quarterly, to perform its assigned functions. Records of its proceedings and actions shall be maintained in accordance with the System's Records Retention and Disposition Policy.

7.3 Staff Functions

- 7.3.1 The PLC exists to promote communication, collaboration and coordination between physicians, System and facility administration and the Board concerning the work of each FMEC and planning activities of the Lee Memorial Health System that impact members of the Medical Staff.

7.4 Facility Medical Executive Committee (FMEC) Composition Selection and Tenure

- 7.4.1 Each Medical Staff may determine the number of Medical Staff members appointed or elected to the FMEC. The composition of the FMEC shall consist of at least the following voting members: Facility President of the Medical Staff, Facility Immediate Past President, Facility President-Elect of the Medical Staff, Facility Secretary/Treasurer, physician representative from the System Credentialing/Privileging Committee, Chair of the Facility Quality Committee, the Department Chairs from Medicine, Surgery, Anesthesiology, Radiology, Pathology, Pediatrics, Obstetrics/Gynecology and Emergency Services, two (2) at-large active members of the Medical Staff appointed by the FMEC and two (2) at-large active members of the Medical Staff elected by the general Medical Staff.

One Board member, the CAO, the facility Vice-President of Nursing, the facility Medical Director (as appropriate) will serve in a non-voting, ex-officio capacity. The Facility President of the Medical Staff shall serve as the Chair of the FMEC.

- 7.4.2 Each FMEC composition description shall be listed in the Facility Rules & Regulations.
- 7.4.3 FMEC members shall disclose in writing to the Medical Staff, prior to the date of election or appointment, any personal, professional or financial applications or responsibilities with Lee Memorial Health System and any competing hospital, healthcare organization or Health System.

FMEC members shall serve 2-year terms, except Facility Past President and Facility President-Elect shall serve 1-year terms. The FMEC and the Nominations Committee shall stagger the terms of appointed and elected at-large members to ensure continuity of leadership. Such physicians must be on Active Staff and be a member in good standing at all times.

All FMEC members are expected to participate in orientation and continuing education activities as related to the operation of the Medical Staff.

7.5 Duties and Responsibilities of the Facility Medical Executive Committees

- 7.5.1 To represent, to initiate action and act on behalf of the Medical Staff members with privileges at the Facility in fulfilling the duties of Medical Staff self governance, credentialing/privileging and quality/peer review, after seeking input and recommendations from Sections and/or Departments affected by FMEC action (if applicable).

- 7.5.2 To receive recommendations from the System Credentialing/Privileging Committee and the Facility Quality/Peer Review Committee and make recommendations to the Board (and for informational purposes only) to the PLC concerning:
 - 7.5.2.1 appointments, reappointments and granting of clinical privileges;
 - 7.5.2.2 necessity for special investigations of issues pertaining to practitioner competence of behavior;
 - 7.5.2.3 needed performance improvements and peer review results;
 - 7.5.2.4 policies and procedures development and enforcement;
 - 7.5.2.5 facility Medical Staff Department and committee structure; and
 - 7.5.2.6 other matters relevant to the provision of patient care, operation of the Medical Staff or proposed Bylaws amendments.
- 7.5.3 Receive or act upon reports and recommendations concerning patient care quality and appropriateness reviews, evaluation and monitoring functions, and the discharge of their delegated administrative responsibilities;
- 7.5.4 Recommend to the Board, and for information purposes only to the PLC, specific programs and systems to perform Medical Staff peer review, quality monitoring, communication, governance, credentialing/privileging and planning functions;
- 7.5.5 Coordinate the implementation of policies adopted by the Board;
- 7.5.6 Oversee the facility multi-specialty peer review and quality monitoring activities in a manner consistent with federal and state law;
- 7.5.7 Take reasonable steps to encourage professionally ethical conduct and competent clinical performance of Medical Staff members at the facility including collegial and educational efforts;
- 7.5.8 Participate in identifying community health needs and in setting facility-specific goals and implementing programs to meet those needs;
- 7.5.9 Design and implement facility-specific rules and regulations that will not conflict with the Medical Staff Bylaws;
- 7.5.10 Work with Facility and System administration to promote effective, efficient and safe patient care practice within the facility;
- 7.5.11 Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff appointees including initiating investigations, and pursuing corrective action, when warranted;
- 7.5.12 Provide oversight concerning the quality and safety of the care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and the Board.

Reviews and ensure corrective action regarding applicable Residency Review Commission findings and recommendations;

- 7.5.13 Keep the Medical Staff up to date concerning the licensure and accreditation status of the System and hospitals;
- 7.5.14 Request evaluations of practitioners privileged through the Medical Staff process in instances in which there is question about an applicant or member's ability to perform privileges requested or currently granted;
- 7.5.15 Consult with administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the hospital by entities outside the hospital;
- 7.5.16 Hold Medical Staff leaders, committees, and Departments accountable for fulfillment of their duties and responsibilities;
- 7.5.17 Advise and assist the PLC, when and to the extent possible, as requested by the PLC, the Board and the System or Facility administration;
- 7.5.18 Grant, deny or rescind exemptions related to ED call responsibility;
- 7.5.19 Meetings: The FMEC shall meet ten (10) times per year, or more frequently as needed to perform its assigned functions. Records of its proceedings and actions shall be maintained in accordance with the System's Records Retention and Disposition Policy.

7.6 System Medical Staff Committees

7.6.1 Purpose. There shall be system Medical Staff committees established by the Medical Staff to carry out the responsibilities of the Medical Staff with regard to measuring and assessing the performance of the Medical Staff providing medical care within the hospitals and Health System facilities.

7.6.2 Organization to Perform Functions. The PLC with the input and approval of each FMEC shall establish system Medical Staff committees comprised of members of the Medical Staff and others as may be deemed appropriate or necessary. The delineation of specific duties, committee size, liaison with other committees and Departments, and other matters necessary to the efficient performance of Medical Staff functions shall be set forth in these Bylaws. The only voting members of system Medical Staff committees are members of the Medical Staff unless otherwise determined by the FMEC. System Medical Staff committees consist of the following, shall report to and through the FMECs on matters relating to all FMECs, and shall report to each FMEC on facility specific matters:

7.6.2.1 **System Credentialing/Privileging Committee** (See Part III, Section 1 of these Bylaws);

7.6.2.2 **System Medical Staff Quality Committee** (See Medical Staff Quality Manual);

7.6.2.3 **System Practitioner Resource Committee**.

Membership:

Membership shall be established by the PLC with the input and approval of each FMEC. The term of office shall be for a period of two (2) years with staggered terms, so as to provide continuity and development of expertise.

Referrals:

Concerns that a member of the Medical Staff may be suffering from a physical or mental impairment that might impact their ability to practice medicine or may be a threat to themselves or others, including but not limited to impairment due to substance abuse, should be communicated to the President of the Medical Staff or to the affected practitioner's Department Chair. The President of the Medical Staff or Department Chair, after consultation with others, if deemed appropriate, may refer the affected practitioner to the practitioner Resource Committee for review, evaluation and follow-up.

Responsibilities:

The committee shall have no authority to take disciplinary action. Nor does the committee provide treatment. The committee is responsible to:

- 7.6.2.3.1 Receive and evaluate concerns about practitioner health and functioning;
- 7.6.2.3.2 Provide assistance and encourage a practitioner impaired by virtue of physical or psychiatric condition, problems in living, or issues related to alcohol use or drug use to voluntarily accept referral for the evaluation, treatment or assistance;
- 7.6.2.3.3 Assume an advocacy role on behalf of the affected practitioner;
- 7.6.2.3.4 Serve as an advisor to the President of the Medical Staff, Department Chair and/or FMEC, including advice relating to alternatives in the event that the practitioner fails to accept referral or fails to adequately recover from treatment;
- 7.6.2.3.5 Consider referring an affected practitioner to appropriate resources for treatment and advice on the appropriateness of treatment, rehabilitation planning and monitoring provisions;
- 7.6.2.3.6 Utilize the Florida Medical Association Physician Resource Network, Intervention Project for Nurses or other resources, if appropriate;
- 7.6.2.3.7 Maintain the confidentiality of information regarding matters referred to the committee;
- 7.6.2.3.8 Refer to the Medical Staff President Department Chair or FMEC those situations that may require possible corrective actions.

7.6.2.4 System Bylaws Committee

Membership:

The Bylaws Committee shall be a standing committee of the Medical Staff and shall be composed of at least five (5) active Medical Staff appointees (including one (1) member from each FMEC appointed by the facility Medical Staff President) and the System Chief Medical Officer (CMO) or his designee (who shall serve as a non-voting member).

Duties:

The duties of the Bylaws Committee shall be to:

- 7.6.2.4.1 Conduct an annual review of the Medical Staff Bylaws, Medical Staff Rules and Regulations and Policies; and
- 7.6.2.4.2 Review recommendations for changes in the Medical Staff Bylaws, Rules and Regulations and Policies made by the Medical Staff committees, Departments, or by the Board.

Meetings, Reports and Recommendations:

The Bylaws Committee shall meet at least annually or as necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the FMECs.

7.6.2.5 System Emergency Services Committee

Membership:

The System Emergency Services Committee shall be an ad hoc committee of the Medical Staff and shall be composed of the Emergency Department Medical Directors, at least three (3) Active Staff members, and other Active Staff members as needed.

Duties:

The duties of the System Emergency Services Committee shall be to:

- 7.6.2.5.1 conduct an annual review of system-wide emergency services;
- 7.6.2.5.2 ensure emergency call is fair to physicians while providing adequate coverage to patients of our community;
- 7.6.2.5.3 review emergency call rules system-wide for recommendation to FMECs.

Meetings:

The System Emergency Services Committee will meet at least once per year or as needed.

7.6.3 Composition and Meetings of System Medical Staff Committees:

- 7.6.3.1 Unless otherwise provided for in these Bylaws, System Medical Staff committees shall be composed of physician members from each facility, as appointed by each FMEC;

- 7.6.3.2 Each System Medical Staff committee shall elect a physician Chairperson and physician vice Chairperson for their respective committee;
- 7.6.3.3 System Medical Staff committee members shall serve terms of 2 years and may be reappointed;
- 7.6.3.4 System Medical Staff committee members who cease to be members of the Medical Staff of Lee Memorial Health System shall automatically cease to serve as committee members. Vacancies on committees shall be filled by the appropriate FMEC;
- 7.6.3.5 System Medical Staff committees shall meet as often as necessary to discharge the duties of the respective committees in accordance with these Bylaws.

Reasonable notice of meetings shall be provided to committee members and may include providing a written schedule of meetings on an annual or more frequent basis.

7.7 Facility Medical Staff Committees:

- 7.7.1 Purpose: There shall be committees to carry out certain essential functions within each facility as determined by each FMEC. The FMEC may establish such committees from time to time in addition to those set forth in the Bylaws.
- 7.7.2 Standing Facility Medical Staff Committees: The following facility committees are approved as standing committees of the FMEC:
 - 7.7.2.1 GCMC Credentialing/Privileging Committee (see Part III, Section 1 of these Bylaws);
 - 7.7.2.2 LMHS Credentialing/Privileging Committee (see Part III, Section 1 of these Bylaws);
 - 7.7.2.3 Nominations Committees (See Part 1, Section 5.3 of these Bylaws);
 - 7.7.2.4 Facility **Medical Staff Quality Committees** (see Medical Staff Quality Manual);
 - 7.7.2.5 Facility Rules and Regulations Committees

Composition: The Facility Rules and Regulations Committee shall be a standing committee of the Medical Staff and shall be composed of at least two (2) active Staff members appointed by the FMEC.

Duties: The duties shall be to review and recommend changes in the Facility Rules and Regulations and policies to the FMEC.

- 7.7.2.6 Trauma Quality Management

Composition, membership and duties are mandated by the State regulations for designated trauma centers.

SECTION 8 MEDICAL STAFF MEETINGS

8.1 General Medical Staff Meetings

- 8.1.1 An annual meeting and other general Medical Staff meetings shall be held at a time determined by the FMEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously at least ten (10) days before the meeting.
- 8.1.2 Except for Bylaws amendments or as otherwise specified in these Bylaws, the actions of a majority of the members present and voting at a meeting of the Medical Staff is the action of the group.

Action may be taken without a meeting of the Medical Staff by presentation of the question to each Medical Staff member eligible to vote, in person, via telephone, and/or by mail or internet, and their vote recorded in accordance with procedures approved by the FMEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

8.1.3 Special Meetings of the General Medical Staff

- 8.1.3.1 The President of the Medical Staff may call a special general Medical Staff meeting at any time. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special general Medical Staff meeting.
- 8.1.3.2 Written or electronic notice stating the time, place and purposes of any special general Medical Staff meeting shall be conspicuously posted and shall be sent to each member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special general Medical Staff meeting, except that stated in the notice of such meeting.

8.2 Departments, Sections and Committee Meetings

- 8.2.1 Regular Meetings of Medical Staff Departments, Sections and Committees
- 8.2.2 Departments, Sections and Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

8.3 Special Meetings of Departments, Sections and Committees

- 8.3.1 A special meeting of any Department, Section or Committee may be called by the Chair thereof or by the President of the Medical Staff.

8.4 Quorum

- 8.4.1 Medical Staff meetings: Unless otherwise specified in these Bylaws, a quorum shall consist of those present or those eligible Medical Staff members voting on an issue.

- 8.4.2 FMEC, Credentialing/Privileges Committee, Medical Staff Quality/Peer Review Committee: A quorum will exist when 50% of the members are present.
- 8.4.3 Departments, Sections or Committees other than those listed in Sections 6 and 7 above or unless otherwise specified in these Bylaws, a quorum shall consist of those present or those eligible Medical Staff members voting on an issue.

8.5 Attendance Requirements

- 8.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.
 - 8.5.1.1 FMEC, Credentialing/Privileges Committee, and Medical Staff Quality/Peer Review Committee meetings: Members of these committees are expected to attend at least 75% of the meetings held.
 - 8.5.1.2 Special meeting attendance requirements: Whenever there is suspected or actual non-compliance with Medical Staff or hospital policies or suspected deviation from standard clinical or professional practice, the President of the Medical Staff or the applicable Department/Section/Committee Chair may require the practitioner to confer with him or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting, by personal delivery or U.S. Mail certified return receipt requested, at least five (5) days prior to the meeting, including the date, time, place, a statement of the issue involved and that the practitioner's appearance is mandatory.

Failure of the practitioner to appear at any such meeting after two (2) notices, unless excused by the FMEC upon showing good cause, will result in an automatic termination of membership pursuant to the Automatic Suspension and Termination provisions of these Bylaws. Such termination will not give rise to a fair hearing, but will automatically be rescinded upon the practitioner's participation in the previously referenced meeting.
 - 8.5.1.3 Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

8.6 Participation by Administration

- 8.6.1 Administration may attend any general, Department, Section or Committee meetings of the Medical Staff, unless otherwise specified or requested by the committee.

8.7 Robert's Rules of Order

- 8.7.1 Medical Staff Department, Section and Committee meetings shall be run in a manner determined by the individual who is the Chair of the meeting. When parliamentary procedure is needed, as determined by the Chair or evidenced by a majority vote of those attending the meeting, the latest edition of *Robert's Rules of Order* shall determine procedure.

8.8 Notice of Meetings

8.8.1 Unless otherwise specified in these Bylaws, written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department or committee not less than five (5) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

8.9 Action of PLC, FMEC, General Medical Staff, Department, Section or Committee

8.9.1 The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a Department, Section and Committee, FMEC, PLC or General Medical Staff meeting. Such recommendation will then be forwarded to the FMEC for action.

8.10 Rights of Ex Officio Members

8.10.1 Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, (except that they shall not vote or be counted in determining the existence of a quorum).

8.11 Minutes

8.11.1 Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding Chair shall authenticate the minutes and copies thereof shall be submitted to the FMEC or other designated committee. Minutes shall be maintained in accordance with the System's Records Retention and Disposition Policy.

SECTION 9 DECISION MAKING METHODS AND CONFLICT RESOLUTION

9.1 FMEC recommendations will be forwarded to the PLC for information and to ensure communication between all facility Medical Staffs, System and facility administration and Board leaders. Routine FMEC communication and recommendations that are consistent between the FMECs and that are consistent with Medical Staff and hospital policy and procedures will be transmitted to the Board.

9.2 Conflict resolution: If the PLC determines a recommendation of a FMEC may be contrary to the opinion of the PLC, or if a decision of the Board is contrary to a recommendation of the PLC and/or a FMEC, the PLC shall not make a recommendation to the Board regarding such matter. The PLC will first refer the matter back to the FMEC(s) for further consideration at their next meeting, together with pertinent suggestions and comments of the PLC.

9.3 If the FMEC recommendation and the opinion of the PLC remain inconsistent after the next meeting of the FMEC, the matter will be referred to an Initial Joint Conference Committee to be convened within thirty (30) days of that FMEC meeting. Such Initial Joint Conference Committee may be convened at any time sooner by mutual agreement of the FMEC and PLC. The Initial Joint Conference Committee shall be composed of two (2) representatives selected by the PLC, two (2) representatives selected by the FMEC, one (1) administrative representative and one (1) Board member.

- 9.3.1 The positions established at the Initial Joint Conference Committee will be reported in full to the FMEC and the PLC. The FMEC will discuss the issue at its next meeting. In the event the FMEC(s)' recommendation remains contrary to the opinion of the PLC, the recommendation of the FMEC(s) shall be forwarded to the Board, along with pertinent, applicable information.

The PLC, at its discretion, may include a divergent opinion along with pertinent, applicable information. The Board shall have sixty (60) days to adopt the recommendation of the FMEC(s), or may choose to refer the matter(s) to a Final Joint Conference Committee at any time within the 60-day period.

9.4 A Final Joint Conference Committee will be convened if:

- 9.4.1 requested by the Board;
- 9.4.2 requested by the PLC, FMEC(s) or Initial Joint Conference Committee (if the Initial Joint Conference Committee is unable to resolve conflicts and divergent opinions remain between the PLC, FMEC(s) and/or Initial Joint Conference Committee); or
- 9.4.3 in the event the Board does not accept or adopt a recommendation by the FMEC(s) within sixty (60) days of receiving such recommendation(s) as set forth in Section 9.3.1.

The Final Joint Conference Committee will convene within thirty (30) days of such request, or occurrence. The Final Joint Conference Committee will be composed of two (2) representatives selected by the PLC, two (2) representatives selected by the FMEC and two (2) representatives (which may or may not be Board members) of the Board for review and recommendation to the full Board. The Final Joint Conference Committee will have up to sixty (60) days to report its recommendation(s), and will issue its complete report simultaneously to the FMEC(s), PLC, Initial Joint Conference members and Board. If either the FMEC(s) or PLC continues to have a dissenting opinion/recommendation from that of the Final Joint Conference Committee, both (FMEC and PLC) shall each have the right for a representative of each to report its recommendation/opinion at the same time to the Board. After such report(s), the Board will make a determination, which shall be final.

- 9.5 The Chair of the Board, PLC or FMEC may call for an Initial Joint Conference as described above at any time and for any reason in order to seek direct input from the Board, PLC and/or FMEC Medical Staff leaders, clarify any issue, or relay information directly to Medical Staff leaders.
- 9.6 The provisions of this article are not applicable to matters subject to the provisions of the Medical Staff Bylaws, Rules and Regulations, or Policies relating to Peer Review, Corrective Action or the Fair Hearing process.

SECTION 10 REVIEW, REVISION, ADOPTION, AND AMENDMENT

10.1 Medical Staff Responsibility

- 10.1.1 The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any Medical Staff Bylaws, rules, regulations, policies and procedures, and amendments as needed, which shall be effective when approved by the Board.

The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

10.2 Methods of Amendment and Adoption to these Bylaws

10.2.1 Proposed amendments to these Bylaws may be originated by the System Bylaws Committee for consideration of all FMECs and each general Medical Staff or by a petition signed by twenty-five (25) active staff members.

10.2.1.1 Each active member of the Medical Staff will be eligible to vote on the proposed amendment to these Bylaws via printed or secure electronic ballot in a manner determined by the FMEC. All active members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. Proposed amendments must:

10.2.1.1.1 receive a simple majority of the votes cast by those active Medical Staff members eligible to vote at the initiating FMEC;

10.2.1.1.2 receive a simple majority of the votes cast by the active Medical Staff members eligible to vote at each FMEC;

10.2.1.1.3 receive a simple majority of the votes cast by the active Medical Staff members eligible to vote on each facility general Medical Staff.

10.2.1.2 Amendments so adopted shall be effective when approved by the Board. Neither the Board nor the Medical Staff shall have the power or authority to unilaterally adopt or amend Medical Staff Bylaws.

10.3 Methods of Amendment and Adoption to any Medical Staff Rules, Regulations and Policies:

10.3.1 The Medical Staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. A Rules, and Regulations and Policies Manual may be utilized to organize these additional documents. Should a conflict exist between the provisions of the Medical Staff Bylaws and the Rules and Regulations or Medical Staff Policies, the Bylaws will prevail. Should a conflict exist between the provisions of the Rules and Regulations and the Medical Staff Policies, the Rules and Regulations will prevail.

10.3.2 Proposed amendments to the Rules, Regulations and Policy Manual may be originated by the FMEC.

10.3.3 The Medical Staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty-five (25) active Medical Staff members. Upon presentation of such petition, the adoption process outlined in 10.2.1 above will be followed.

10.3.4 The FMEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the FMEC, any of these documents may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the Board, subject to Section 9 of this Part in the event of a conflict.

- 10.4 The FMEC may adopt such amendments to these Bylaws, Rules and Regulations, and policies that are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering or those needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the System CEO.

Appendix A
PRINCIPLES OF MEDICAL ETHICS**

- PREAMBLE The medical professions have long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a health professional must recognize responsibility to patients first and foremost, as well as to society, to other health professionals and to self. The following Principles are not laws but standards of conduct, which define the essentials of honorable behavior for the health professional.
- Section 1 A health professional shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.
- Section 2 A health professional shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report health professionals deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- Section 3 A health professional shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.
- Section 4 A health professional shall respect the rights of patients, colleagues, and other health professionals and shall safeguard patient confidences and privacy within the constraints of the law.
- Section 5 A health professional shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professions when indicated.
- Section 6 A health professional shall, in the provision of appropriate patient care, except in emergencies be free to choose whom to serve, with whom to associate and the environment in which to provide medical care.

- Section 7 A health professional shall recognize a responsibility to participate in activities contributing to an improved community and the betterment of public health.
- Section 8 A health professional shall, while caring for a patient, regard responsibility to the patient as paramount.
- Section 9 A health professional shall support access to medical care for all people.

**Adapted from the American Medical Association's "Principles of Medical Ethics" (adopted by the AMA's House of Delegates June 17, 2001).

PART II: INVESTIGATIONS, CORRECTIVE ACTION, HEARING AND APPEAL PLAN

SECTION 1 ROUTINE CORRECTIVE ACTION & INVESTIGATIONS

1.1 Progressive Intervention

These Bylaws encourage the use of progressive steps by Medical Staff leaders and hospital administration, beginning with collegial and education efforts, to address questions relating to a practitioner's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the practitioner to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and hospital management are part of the hospital's performance improvement and professional review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and hospital administration. When any observations arise, suggesting opportunities for a practitioner to improve, the matter may be referred in accordance with the performance improvement and professional conduct policies adopted by the Medical Staff and hospital.

Corrective actions and investigations shall be undertaken:

- 1.1.1 in the reasonable belief that the action is in the furtherance of quality health care;
- 1.1.2 after a reasonable effort to obtain the facts of the matter,
- 1.1.3 after adequate notice and hearing procedures are afforded to the practitioner as set forth herein, and
- 1.1.4 in the reasonable belief that the action is warranted by the facts known after such reasonable effort to obtain the facts.

1.2 Basis for Routine Corrective Action

Whenever a concern or question has been raised regarding:

- 1.2.1 the clinical competence or clinical practice of any appointee;
- 1.2.2 the care or treatment of a patient or patients or management of a case by any appointee;
- 1.2.3 activities or professional conduct that may be detrimental to patient safety;
- 1.2.4 the known or suspected violation by any Medical Staff appointee of these Bylaws, the Policies, or the Rules and Regulations of the Medical Staff, System or Department
- 1.2.5 behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the hospital, disruptive to the hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others; or
- 1.2.6 impairment,

a request for corrective action may be made by any practitioner on the Medical Staff, any member of the System administration, System or Medical Staff committee, or the Board of Directors, after making sufficient inquiry to satisfy themselves that the concern or question raised is credible.

1.3 Requests and Notices

All requests for corrective action shall be made in writing to the President of the Medical Staff and the Chief Medical Officer, with a copy to the Medical Staff Services Office. The request must be signed by the complainant, clearly state those facts that support the request in sufficient detail to permit an investigation to be pursued, and, if possible, state what corrective action is deemed appropriate by the complainant. The President of the Medical Staff shall notify the FMEC at its next regular meeting that a request for corrective action has been made. The affected practitioner shall be given written notice of the request, and a copy of the same. All notices provided under this Part II shall be hand delivered or sent via certified mail, return receipt requested. All time limits shall begin upon receipt of notice.

1.4 Investigations

- 1.4.1 When a request for corrective action has been received by the FMEC, the committee shall determine as soon as possible, but no later than at its next regularly scheduled meeting, either to discuss the matter with the appointee concerned, or to begin an investigation. If the concern states sufficient information to warrant action, the FMEC, at its discretion, may initiate an investigation, with or without a personal interview with the practitioner being investigated. The FMEC may seek input from the practitioner's Department or Section prior to initiating investigation. An investigation shall begin only after a formal resolution of the FMEC to that effect. The affected practitioner shall be given written notice of the initiation of an investigation. If the Board of Directors wishes to begin such an investigation, it shall also formally resolve to do so by mandating the FMEC to begin an investigation.
- 1.4.2 Upon resolving to initiate an investigation, the Medical Staff President through the FMEC or President of the Medical Staff shall immediately appoint a member(s) of the Active Medical Staff to conduct an investigation of the matters contained in the request. Investigators shall not include partners, associates or relatives of the practitioner being investigated and should be objective and familiar with the types of issues raised in the request for corrective action.
- 1.4.3 The investigator(s) may consult with other members of the Medical Staff as appropriate in order to determine the facts of the case, or to obtain professional opinions relative to the matter under consideration.
- 1.4.4 The investigator(s) shall have available the full resources of the Medical Staff and the System, as well as the authority to use outside consultants, if needed.
- 1.4.5 The investigation should be completed within thirty (30) working days of the appointment of the investigator(s), unless an extension of not more than thirty (30) additional working days has been granted by the FMEC or President of the Medical Staff.
- 1.4.6 At the conclusion of the investigation, the investigator(s) shall prepare a written report of the findings and transmit the same to the President of the Medical Staff and the Chief Medical Officer. In addition to setting forth findings of fact and, if applicable, the clinical opinion of the investigator(s) and other practitioners with whom he may have consulted, the report shall recommend that corrective action be imposed, or that the complaint against the affected practitioner be dismissed.

The investigator may recommend a type or degree of corrective action deemed appropriate.

- 1.4.7 The President of the Medical Staff shall review the investigator's report when it is received, and if emergency corrective action is indicated, proceed to impose the same pursuant to Section 2 of this part. Otherwise, the President shall submit the investigator's report to the FMEC for consideration at its next regular meeting.
- 1.4.8 In cases suggesting practitioner impairment, the President of the Medical Staff shall confer with a member of the Medical Administrative Staff, designated by the System President and the practitioner's Department Chair, and if they concur, shall refer the request to the Practitioner Resource Committee for disposition; otherwise, the request shall be referred to the FMEC for consideration at its next regular meeting.

1.5 FMEC Action

- 1.5.1 If the FMEC determines that there are no reasonable grounds to believe that the affected practitioner has committed an offense requiring corrective action under these Bylaws, the complaint shall be dismissed. The affected practitioner and complainant shall be given written notification of dismissal.
- 1.5.2 If the FMEC determines that there are reasonable grounds to believe that the affected practitioner is subject to corrective action, the Committee may elect to recommend corrective action to the Board, which, at the discretion of the FMEC, may consist of:
 - 1.5.2.1 A written warning that corrective action measures will be taken in the future if the affected practitioner does not reform his conduct in the manner set forth in the warning;
 - 1.5.2.2 A written reprimand stating the Committee's displeasure at the affected practitioner's behavior, and directing the affected practitioner to cease the same immediately;
 - 1.5.2.3 Mandated education to improve the affected practitioner's knowledge, skills and ability in clinical as well as non-clinical subjects;
 - 1.5.2.4 Mandated clinical review or supervision to see that the affected practitioner's performance attains an acceptable level;
 - 1.5.2.5 Limitation of privileges restricting those procedures that the affected practitioner may perform at the Facility;
 - 1.5.2.6 Removal of privileges eliminating the affected practitioner's ability to perform any procedure at the Facility. If the affected practitioner is a member of the Medical Staff, removal of privileges shall also entail revocation of Medical Staff membership. If removal of privileges is recommended at the time of the affected practitioner's biennial reappointment, this may be accomplished by not recommending the affected practitioner for reappointment;
 - 1.5.2.7 Make such other recommendations, as it deems necessary or appropriate.

1.6 Notice of FMEC Action

Whenever a recommendation for corrective action has been made by the FMEC, or corrective action has been taken by the Board on its own initiative, written notice of the same shall be sent to the affected practitioner by certified mail, return receipt requested, or hand delivery with receipt. Such notice shall be consistent with the notice provision set forth in Subsection 1.3. The notice shall set forth the nature of the complaint, the reasons for the corrective action, a description of the corrective action, and a short summary of the affected practitioner's right to a fair hearing pursuant to these Bylaws, including any time limits within which the affected practitioner must act. The affected practitioner may request a hearing pursuant to the provisions of Section 4.

1.7 Board of Directors Action

If the time, during which an affected practitioner may request a hearing pursuant has expired without a request being made, or such hearing, including appeal to the Board, has been concluded, then at the next regular meeting thereafter of the Board of Directors, the Board shall consider the recommended corrective action. In the event that the Board rejects such recommendation, the Board may remand the recommendation to the FMEC with instructions to reconsider the matter, including the nature and degree of the corrective action. The Board shall consider recommendations of the FMEC following remand in the same manner as other recommendations for corrective action.

SECTION 2 EMERGENCY CORRECTIVE ACTION/PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

2.1 Basis for Emergency Corrective Action/Precautionary Suspension

The President of the Medical Staff, the Chief Medical Officer (or his designee), or the FMEC shall have the authority to immediately suspend all or any portion of the clinical privileges of a Medical Staff practitioner or other individual, whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension, nor shall it entitle the practitioner to a fair hearing except as provided under this Section. Those parties with the authority to impose emergency corrective action shall consult with a physician member of the Administration designated by the System President and System legal counsel before imposing any emergency corrective action. This Subsection shall not apply if a clear and present danger exists which requires immediate action and consultation is not feasible.

2.2 Notice of Emergency Corrective Action/Precautionary Suspension

Upon imposition of emergency corrective action, the President of the Medical Staff shall immediately give notice to the affected practitioner of such action.

Such notice may be oral, but shall be confirmed in writing as soon as possible, but no later than the next business day. The written notice shall state the reasons for the emergency corrective action and the nature of corrective action imposed. A copy of the notice shall also be given to the Chief Medical Officer, Department Chair, and FMEC.

2.3 FMEC Procedure

When instituted, a precautionary suspension of clinical privileges will automatically expire in seven (7) days, unless extended by the FMEC, with return of all previous clinical privileges unless the suspension is confirmed by a majority vote of the FMEC in special session. The FMEC shall review the matter resulting in precautionary suspension within a reasonable period not to exceed fourteen (14) days. Unless the FMEC promptly terminates or extends the precautionary suspension prior to or immediately after reviewing the suspension, the practitioner shall be entitled to the procedural rights afforded by the Fair Hearing and Appeal plan once the restrictions or suspension last more than fourteen (14) calendar days. Restrictions or suspensions which last fourteen (14) days or less shall not trigger rights under the Fair Hearing and Appeal Plan.

2.4 Provision of Patient Care

Immediately upon the imposition of a precautionary suspension, the appropriate Department Chair or, if unavailable, the President of the Medical Staff shall assign responsibility for care of the suspended practitioner's patients still in a System's facility to another practitioner with appropriate clinical privileges. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned practitioner. It shall be the duty of all Medical Staff practitioners to cooperate with the President of the Medical Staff, the Department Chair concerned, the FMEC and the Chief Medical Officer in enforcing all suspensions.

2.5 Recission of Emergency Corrective Action/Precautionary Suspension

The person imposing emergency corrective action may, at any time prior to ratification of such action by the FMEC, rescind the action, and the affected practitioner shall be restored to the status he enjoyed prior to the imposition of emergency correction action. Following ratification of emergency corrective action by the Executive Committee, the person imposing such action may recommend to the FMEC that such action be rescinded. The FMEC shall consider such recommendation at its next regular meeting thereafter. Any pending request for a hearing pursuant to Section 4 shall be made moot and void by such recission.

SECTION 3 AUTOMATIC SUSPENSION AND TERMINATION

3.1 Basis for Automatic Suspension and Termination

A practitioner's clinical privileges shall automatically be revoked, limited or suspended as appropriate, which action shall be final without a right to due process except as provided in this Section, upon the occurrence of the following circumstances:

3.1.1 Loss of License. The practitioner's license to practice in the State of Florida is suspended, limited or terminated.

3.1.2 Residence or Office Outside Lee County.

The practitioner does not maintain a full-time residence and office in Lee County as required by these Bylaws, unless such requirements are waived by the FMEC pursuant to said Subsection. Return of United States mail sent by the System Medical Staff Services Office to a practitioner at his Lee County home or office address with "addressee unknown" or similar endorsement shall be prima facie

evidence that the practitioner does not comply with these Bylaws. Failure of a practitioner to supply a current residence and office address within 15 working days of a request of the Medical Staff Services Office for the same shall be deemed prima facie evidence that the practitioner does not comply with these Bylaws. This shall not apply to practitioners granted a leave of absence by the FMEC pursuant to these Bylaws.

- 3.1.3 Lack of Active Practice. The practitioner is not actively engaged in the practice of his profession in Lee County; that is, he is not seeing, examining, treating or otherwise caring for patients, and has not done so for a period of more than six months, unless the practitioner shall have notified the Medical Staff Services Office prior to beginning such absence, and arranged for suitable coverage during such time period. This shall not apply to practitioners granted a leave of absence by the FMEC pursuant to these Bylaws, or to members of the Honorary Medical Staff.
- 3.1.4 Criminal Conviction. The practitioner has been, while a practitioner on the Medical Staff, convicted in any jurisdiction of the United States; of a felony or misdemeanor involving actual or threatened bodily harm, actual or threatened sexual misbehavior or stalking, controlled substance possession or use, or of any felony or misdemeanor described in any Florida law pertaining to governing or regulating the health professions or health facilities. A practitioner whose membership or privileges are automatically terminated pursuant to this Subsection shall not be disqualified from applying for appointment following completion of his sentence, or during a period of time when he is on probation. However, the fact that the practitioner has completed his sentence after criminal conviction, or is on probation, shall not require the Medical Staff to make such appointment, and the FMEC may elect not to do so in its discretion, consistent with its responsibility towards patients, other practitioners, Facility/System employees, and the public in general.
- 3.1.5 Loss or Restriction of DEA Certificate. The clinical privileges of a practitioner whose Drug Enforcement Agency (DEA) certification is terminated, revoked, or suspended shall automatically and immediately be modified to revoke the right to prescribe controlled substances. The practitioner shall immediately inform the Medical Staff Services Office regarding the change in status in his DEA certification. The matter shall promptly be referred, for investigation and further action in accordance with the provisions of these Bylaws.
- 3.1.6 Exclusion From Federal or State Health Care Programs. The Medical Staff appointment and clinical privileges of a practitioner who becomes an ineligible person with regard to participation in Federal or State Health Care Programs shall automatically and immediately be suspended.

The practitioner shall immediately inform the Medical Staff Services Office regarding the change of his eligibility status. This triggers the right to due process. The matter shall promptly be referred for investigation and further action in accordance with all the due process provisions of this Part.
- 3.1.7 Failure to Pay Fees and Assessments. The practitioner fails to pay when due any fee or assessment imposed pursuant to these Bylaws or Medical Staff or System policy.
- 3.1.8 Failure to Provide Requested Information. If at any time a practitioner fails to provide required information pursuant to a formal request by the System Credentialing/Privileging Committee, Medical Executive Committee or the Medical Staff Services Office, the practitioner's clinical privileges shall be deemed to be

voluntarily relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this Section, required information shall include but not be limited to: 1. physical or mental examination reports as specified elsewhere in this policy, or 2. information necessary to explain an investigation, professional review action, or resignation from another health care facility or agency.

- 3.1.9 Failure to Request Reappointment or Provide Requested Information Related to Reappointment. If a practitioner fails to request reappointment for membership and/or privileges or fails to provide requested information pursuant to Part III, Section 5 of these Bylaws, the practitioner's membership and privileges shall be deemed voluntarily relinquished.
- 3.1.10 Failure to Request Reinstatement Following Leave of Absence. Failure to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. Members whose membership is automatically terminated shall not be entitled to the procedural rights provided in the Medical Staff Bylaws.
- 3.1.11 Failure to Complete Medical Records. All elective admitting, consulting and clinical privileges of any practitioner shall be deemed to be voluntarily relinquished for failure to complete medical records in accordance with the provisions of the Medical Staff Rules and Regulations. Such relinquishment shall continue until all the records of the practitioner's patients are no longer delinquent. Such relinquishment does not exempt the practitioner from fulfilling their on-call responsibilities. Failure to complete the medical records that caused relinquishment of clinical privileges within sixty (60) days from the relinquishment of such privileges shall be grounds for further disciplinary action in accordance with the provisions of these Bylaws.
- 3.1.12 Failure to Comply with Special Meeting Attendance Requirements. Failure of a practitioner to attend a special meeting called pursuant to the Bylaws.

3.2 Right to Limited Hearing for Automatic/Voluntary Suspension and Termination

A practitioner affected by this Section shall be sent a written notice stating the reasons for automatic suspension within 24-hours of the same having been imposed, and shall have the right to present evidence to the FMEC in written form, or by appearing personally at a regular meeting of the committee, to demonstrate that the reason that automatic suspension was imposed is untrue.

- 3.2.1 Such written evidence or a written request to meet with the FMEC shall be submitted to the President of the Medical Staff within ten (10) working days of the date the notice of automatic suspension was sent. Failure to submit written evidence or a request shall be deemed a waiver of any right to consideration of the same.
- 3.2.2 Evidence presented by the affected practitioner shall be limited to whether or not the grounds for automatic suspension are true. The FMEC shall not consider evidence or argument, which presents mitigating circumstances or excuse.
- 3.2.3 After receipt of an affected practitioner's written evidence, and prior to the next regular meeting of the FMEC, the President of the Medical Staff, with the concurrence of a member of the Medical Administrative Staff designated by the System President, may determine that the evidence so presented demonstrates that

the reasons that automatic suspension was imposed are untrue, and revoke the suspension, restoring the affected practitioner to the status he previously enjoyed.

- 3.2.4 The President of the Medical Staff may, at any time, provisionally reinstate a practitioner suspended pursuant to this Section if the President is satisfied by the available written documentation that the reasons for automatic suspension were untrue. The President shall present the provisional reinstatement for ratification by the FMEC at its next regular meeting.
- 3.2.5 At its next regular meeting following automatic suspension, the FMEC shall consider the reasons therefore, together with any evidence or argument presented by the affected practitioner, and if the reasons for automatic suspension are found to be true, recommend to the Board termination of the affected practitioner's Medical Staff membership and/or privileges. If the FMEC finds that the reasons are untrue or corrected, the suspension shall be revoked, and the affected practitioner restored to the status he previously enjoyed.

SECTION 4 HEARING AND APPEAL PROCEDURES

4.1 Grounds for Hearing

An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever the FMEC or the Board of Directors has made one of the following adverse recommendations:

- 4.1.1 denial of initial Medical Staff appointment;
- 4.1.2 denial of Medical Staff reappointment;
- 4.1.3 revocation of Medical Staff appointment;
- 4.1.4 denial of requested initial clinical privileges;
- 4.1.5 denial of requested additional clinical privileges;
- 4.1.6 decrease of clinical privileges;
- 4.1.7 suspension of clinical privileges (other than emergency corrective action/precautionary suspension);
- 4.1.8 imposition of mandatory concurring consultation requirement.

No other recommendations except those enumerated in this Section shall entitle the practitioner to request a hearing.

Neither voluntary relinquishment of clinical privileges, as provided in these Bylaws, nor the imposition of any general consultation requirement, nor the imposition of a requirement for retraining, additional training or continuing education, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in these Bylaws.

4.2 Notice of Recommendation

When a recommendation is made which, according to these Bylaws entitles a practitioner to a hearing prior to a final decision of the Board, the affected practitioner shall promptly be given notice by the President of the Medical Staff or Chief Medical Officer or his designee, in writing, certified mail, return receipt requested or in person. This notice shall contain:

- 4.2.1 a statement of the recommendation made, the action which is being taken or which may be taken, and the general reasons for it;
- 4.2.2 notice that the practitioner has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice; and
- 4.2.3 a copy of this Part outlining the rights in the hearing as provided for in these Bylaws.

4.3 Request for Hearing

A practitioner shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. The request shall be in writing to the President of the Medical Staff or Chief Medical Officer with a copy to the Medical Staff Services Office and signed by the affected practitioner making such request. In the event the practitioner does not request a hearing within the time and in the manner required by these Bylaws, the practitioner shall be deemed to have waived the right to the hearing and to have accepted the action involved. That action shall become effective immediately upon final Board action.

4.4 Preliminary Interview

The affected practitioner may request, at the time of submitting a request for hearing or within ten (10) working days thereafter, an informal preliminary interview with the decision making body (FMEC or Board of Directors). The decision making body shall grant all such requests, and the affected practitioner shall be scheduled to appear before it at its next regular meeting.

- 4.4.1 The purpose of the preliminary interview shall be to permit the affected practitioner to personally present any argument or evidence showing that the adverse recommendation has been wrongfully imposed, in fact, or in violation of these Bylaws; or to present any mitigating circumstances.
- 4.4.2 The preliminary interview is informal and not a hearing. It is optional with the affected practitioner, and accordingly, legal counsel shall be excluded.
- 4.4.3 The decision making body may impose a limit on the amount of time to be devoted to a preliminary interview, but not less than thirty minutes.
- 4.4.4 Failure to request a preliminary interview shall not be considered in any hearing or deliberation conducted pursuant to these Bylaws, nor shall the affected practitioner's right to a hearing be affected thereby.
- 4.4.5 Following a preliminary interview, the decision making body shall deliberate, and may elect to withdraw or reduce the severity of the adverse recommendation imposed upon the affected practitioner, or may take no action. If no action is taken, the adverse recommendation shall continue in effect, and the hearing provided for hereunder shall proceed.
- 4.4.6 Notice shall be given to the affected practitioner of the decision following a preliminary interview in the manner provided in Subsection 1.3.

SECTION 5 FAIR HEARING PROCEDURE

5.1 System Representative, Hearing Panel and Hearing Officer

5.1.1 System Representative

- 5.1.1.1 When the FMEC of the Medical Staff is the decision making body, the President of the Medical Staff shall appoint a person to represent the interests and position of the Medical Staff in all proceedings provided for in this Section. Such individual shall be in an adversarial role opposed to the affected practitioner. If the affected practitioner is not represented by legal counsel, the Medical Staff representative shall not be an attorney, but shall be a member of the Active Medical Staff.
- 5.1.1.2 When the Board is the decision making body, as defined herein, the Chair of the Board shall appoint a person to represent the interests and position of the Board in all proceedings provided for in this Section. Such individual shall be in an adversarial role opposed to the affected practitioner. If the affected practitioner is not represented by legal counsel, the Board representative shall not be an attorney, but shall be a member of the administration.
- 5.1.1.3 For purposes of these Bylaws, the Medical Staff or Board representative appointed under this Section shall be called the "System Representative."

5.1.2 Hearing Panel

- 5.1.2.1 Unless the FMEC or Board elects to have the matter heard by a Hearing Officer possessing the qualifications set forth in Subsection 5.1.3, all hearings shall be conducted by a Hearing Panel appointed by the President of the Medical Staff or the Chair of the Board, as applicable, composed of five (5) members, presided over by a qualified professional selected in accordance with Subsection 5.1.3. The Hearing Panel shall be composed of Active Medical Staff practitioners who shall not have actively participated in the consideration of the matter involved at any previous level. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

If the hearing has been requested based on Board action, 3 of the members of the Hearing Panel shall be members of the Board of Directors. The Hearing Panel will be presided over by a Hearing Officer.

- 5.1.2.2 The Hearing Panel shall not include any individual who is in direct economic competition with the affected person or has any other personal interest in the proceeding, financial or otherwise, or any such individual who is professionally associated with or related to the affected practitioner.

5.1.3 Hearing Officer – Qualifications & Authority

- 5.1.3.1 The FMEC or the Board may elect to have the hearing provided for in this Section held by a Hearing Officer sitting alone. In such case, the Hearing Officer shall perform all of the functions of the Hearing Panel described herein.

In cases where a panel is appointed, the Hearing Officer will preside over the proceeding but not participate in the deliberations or vote on the recommendation.

5.1.3.2 The Hearing Officer:

- 5.1.3.2.1 shall be an attorney licensed in the State of Florida who is knowledgeable and has experience in health care law, including Medical Staff law; or shall be a non-lawyer who has experience as a Hearing Officer;
- 5.1.3.2.2 shall not be, or have been, employed or retained by the Lee Memorial Health System, or any practitioner on the Medical Staff, including the affected practitioner, for any purpose other than to serve as a Hearing Officer in Medical Staff proceedings;
- 5.1.3.2.3 shall have no personal interest in the proceeding, financial or otherwise;
- 5.1.3.2.4 shall be selected by the affected practitioner from a list provided to the affected practitioner by the General Counsel for the Health System of the names of not less than three (3) persons meeting the requirements of 1-3 above. The affected practitioner shall select the Hearing Officer from the list submitted to him and within forty-eight (48) hours of receiving said list, notify the General Counsel for the Health System in writing of said selection.

Failure of the affected practitioner to select within the previously mentioned period shall constitute a waiver by the affected practitioner of this Subsection, and the General Counsel for the Health System shall thereafter select the Hearing Officer.

5.1.3.3 The Hearing Officer shall:

- 5.1.3.3.1 act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
- 5.1.3.3.2 prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, and abusive or that causes undue delay;
- 5.1.3.3.3 maintain decorum throughout the hearing;
- 5.1.3.3.4 determine the order of procedure throughout the hearing;
- 5.1.3.3.5 have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to

matters of procedure and to the admissibility of evidence and qualifications of witnesses;

- 5.1.3.3.6 act in such a way that the Hearing Panel in formulating its recommendations considers all information relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing;
- 5.1.3.3.7 conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present;
- 5.1.3.3.8 grant continuances and postponements as appropriate; and
- 5.1.3.3.9 take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this state, inform the participants of the matters to be officially noticed and provide each party the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority.

5.2 Challenge to Hearing Panel Members or Hearing Officer

The affected practitioner may challenge the objectivity of any member of the Hearing Panel, or the Hearing Officer, at any time prior to the taking of testimony at the hearing. Such challenge shall be in writing and specify facts demonstrating that a member of the Hearing Panel or the Hearing Officer lacks objectivity or is biased against the affected practitioner.

The challenge shall be directed to the President of the Medical Staff or the Chair of the Board, as applicable, who shall consider the challenge and either sustain or overrule it. If the challenge is sustained, the challenged member of the Hearing Panel or the Hearing Officer shall be replaced.

SECTION 6 HEARING PROCEDURES

6.1 Provision of Relevant Information

6.1.1 There is no right to discovery in connection with the hearing. However, the practitioner requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

- 6.1.1.1 copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the practitioner's expense;
- 6.1.1.2 reports of experts relied upon by the FMEC or the Board;
- 6.1.1.3 redacted copies of relevant committee or Department meeting minutes (such provision does not constitute a waiver of the state peer review protection statute); and
- 6.1.1.4 copies of any other documents relied upon by the FMEC or the Board.

- 6.1.2 Prior to the hearing, on dates set by the Hearing Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Hearing Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- 6.1.3 Prior to the hearing, on dates set by the Hearing Officer, the practitioner requesting the hearing shall, upon specific request, provide the FMEC (or the Board of Directors) copies of any expert report or other documents relied upon by the practitioner.
- 6.1.4 Neither the affected practitioner, nor his attorney, nor any other person on behalf of the affected practitioner, shall contact members of the hearing committee or the Hearing Officer, or hospital employees appearing on the hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

6.2 Pre-Hearing Conference

The Hearing Officer may require counsel for the practitioner and for the FMEC (or the Board) to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Hearing Officer may specifically require that:

- 6.2.1 all documentary evidence to be submitted by the parties be presented at this conference; any objections to the documents shall be made at that time and the Hearing Officer shall resolve such objections;
- 6.2.2 evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the practitioner's qualifications for appointment or the relevant clinical privileges be excluded;
- 6.2.3 the names of all witnesses and a brief statement of their anticipated testimony are submitted, if not previously provided;
- 6.2.4 the time granted to each witness' testimony and cross-examination be agreed upon, or determined by the Hearing Officer, in advance; and
- 6.2.5 witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

6.3 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 pending recommendations or actions, which shall then be forwarded to the Board for final action. The Hearing Officer may impose sanctions upon either party for failure to appear, including the assessment of the costs and attorneys' fees of the party in attendance against the offending party.

6.4 Record of Hearing

A record shall be made at the expense of the Lee Memorial Health System, if any, the pre-hearing conference and the hearing, using the services of a court reporter. No record of the in camera deliberations of the decision making body or the hearing committee shall be made. Either party shall be entitled to have a record made of any other proceeding related to the hearing process, at that party's expense. The expense of transcripts shall be borne by the party requesting them. Oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

6.5 Rights of Both Sides

At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Hearing Officer:

- 6.5.1 to call and examine witnesses to the extent available;
- 6.5.2 to introduce exhibits;
- 6.5.3 to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- 6.5.4 to be represented by counsel who may call, examine, and cross-examine witnesses and present the case. (Both sides shall notify the other of the name of that counsel at least ten (10) days prior to the date of the pre-hearing conference and hearing); and
- 6.5.5 to submit a post-hearing memorandum of points and authorities (The Hearing Panel may request such a memorandum to be filed following the close of the hearing).

Any practitioner requesting a hearing, who does not testify on his own behalf, may be called and examined as if under cross-examination. The Hearing Panel or Hearing Officer may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The rules of evidence applicable to the courtroom shall not apply, and the Hearing Officer may admit any evidence that might be relied upon by a reasonable person. Notwithstanding the foregoing, a party shall have the right to object to any evidence on grounds of hearsay, relevance, or other grounds available under the Florida Evidence Code, and the Hearing Officer shall have the authority to rule on such objections.

6.7 Burden of Presenting Evidence and Proof

The burden of going forward with evidence supporting the adverse action or recommendation is on the FMEC or Board, whichever initially prompted the hearing. Once that burden has been met to the satisfaction of the Hearing Panel/Hearing Officer, the practitioner shall bear the burden of proof, under a preponderance of the evidence, which is a lesser standard than clear and convincing evidence, that the action and penalty taken or proposed against the practitioner was wrongfully or arbitrarily imposed, not in accordance with these Bylaws, or lacks any factual basis.

SECTION 7 HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS

7.1 Deliberations and Recommendation of the Hearing Panel/Hearing Officer

- 7.1.1 The recommendation of the Hearing Panel/Hearing Officer shall be based on the evidence produced at the hearing. This evidence may consist of oral testimony of witnesses; memorandum of points and authorities presented in connection with the hearing, any information regarding the practitioner who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it, any and all applications, references, and accompanying documents; other documented evidence, including medical records and any other information presented at the hearing.
- 7.1.2 Within thirty (30) working days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Hearing Officer, and shall prepare a recommended order containing the findings of fact, findings regarding the applicability of these Bylaws, any rules, regulations or policies of the Medical Staff or the Lee Memorial Health System, and the statutory and decisional law of Florida; and a recommendation that adverse action be upheld, modified or withdrawn. If the FMEC or the Board selected a Hearing Officer sitting alone, the Hearing Officer shall prepare a recommended order in the same manner outlined above.
- 7.1.3 The Hearing Officer shall not participate in the deliberations of the Hearing Panel, nor be involved in the decision of the Hearing Panel regarding its recommended order.

However, the Hearing Officer may assist the Hearing Panel with regard to the form, organization and syntax of the recommended order. The recommended order shall be signed by each member of the Hearing Panel or the Hearing Officer, as applicable, and copies provided in person by certified mail, return receipt requested, to the affected practitioner and System Representative.

7.2 Disposition of Hearing Panel Report

The Hearing Panel/Hearing Officer shall deliver its report and recommendation to the Chief Medical Officer or his designee who shall forward it, along with all supporting documentation, to the Board and/or FMEC.

The recommended order shall be considered by the FMEC or Board at its next regular meeting, and may be adopted or rejected by it. If adopted, the recommended order shall become the final decision of the original decision making body (FMEC or Board).

If rejected, the FMEC or Board shall render its own final written decision upholding the original recommendation, modifying or withdrawing the action. Any action imposed through the final order that requires action by the Board of Directors shall be referred to the Board for final disposition at its next regular meeting.

SECTION 8 APPEAL PROCEDURE

8.1 Request & Time for Appeal

Within ten (10) working days of receipt of the final written decision following a hearing, either party may appeal the recommendation. The request shall be in writing, signed by the requesting party and delivered to the Chief Medical Officer either in person or by certified mail, return receipt requested, with a copy to the Medical Staff Services Office. The request shall include a statement of the reasons for appeal and the facts or circumstances that justify further review. If such appellate review is not requested within ten (10) working days

as provided herein, both parties shall be deemed to have waived the right to an appeal, and the Hearing Panel or Hearing Officer's report and recommendation shall be forwarded to the Board for final action.

8.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

- 8.2.1 there was substantial failure to comply with these Bylaws or hospital policies prior to the hearing so as to deny a fair hearing; or
- 8.2.2 the recommendations of the Hearing Panel were made arbitrarily, capriciously or with prejudice.

8.3 Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board shall, as soon as arrangements can reasonably be made, taking into account the schedules of all participants, schedule and arrange for an appellate review. The affected practitioner shall be given notice of the time, place and date of the appellate review. When a request for appellate review is from a appointee who is under a suspension then in effect, the appellate Review panel shall be convened not more than 14-days from the date of receipt of the request for an appeal unless the practitioner agrees to a longer period. The time for appellate review may be extended by the Chair of the Board for good cause.

8.4 Nature of Appellate Review

- 8.4.1 Review panel. The Chair of the Board shall appoint a Review panel composed of 5 members, 3 of the panel members shall be members of the Board of Directors and 2 panel members shall be Active members of the Medical Staff. The Board may establish rules of procedure to govern the conduct of appellate hearings under this Section and the Chair of the Board, or his or her designee, shall preside at appellate proceedings.
- 8.4.2 Position Papers. Each party shall have the right to present a written statement in support of its position on appeal. Position papers that do not conform to the following requirements may be excluded from consideration in the appeal.
 - 8.4.2.1 The position papers shall set forth a statement of the facts and of the applicable Bylaws provisions or other authority, as well as any other matters that the parties wish to bring before the appellate body in support of their respective positions.
 - 8.4.2.2 Twelve copies of the affected practitioner's position paper shall be filed with Medical Staff Services within (fifteen)15 working days of the filing of the notice of appeal. The System Representative shall also file with Medical Staff Services, 12 copies of his position paper within ten (10) working days of his receipt of a copy of the affected practitioner's position paper.
 - 8.4.2.3 Position papers shall be limited to no more than thirty (30) pages, exclusive of exhibits, and shall be on letter-size paper, typewritten, double-spaced and shall be neatly bound or stapled.

- 8.4.2.4 Each party shall provide a copy of his position paper to the other at the same time the party's position paper is filed with Medical Staff Services.
- 8.4.2.5 Exhibits attached to the position paper shall not duplicate exhibits or documents contained in the hearing record, and shall be consecutively numbered and attached at the end of the position paper.
- 8.4.2.6 In referring to the record, position papers shall reference specific pages of the hearing record and of exhibits that are part of the record.
- 8.4.3 Oral Argument. The affected practitioner and the System Representative shall be entitled to present oral argument. Oral argument shall be requested at the time the party submits his position paper. Failure to request oral argument shall constitute a waiver of the right to it. The Board may limit the time for oral argument, but each side shall not have less than thirty (30) minutes. Oral argument shall not include the introduction of evidence and appellate review shall not constitute a hearing de novo. A record shall be made at the expense of the Lee Memorial Health System of the presentation of oral argument, using the services of a court reporter.
- 8.4.4 Recommendation. The review panel shall recommend final action to the Board within thirty (30) working days after the completion of oral argument, or if no oral argument is requested, within forty-five (45) working days after the submission of the position papers of both parties.

SECTION 9 FINAL DECISION OF THE BOARD

Within thirty (30) working days after receipt of the Review panel's recommendation, the Board shall render a final decision in writing, including specific reasons and shall deliver copies thereof to the affected practitioner, the FMEC, and the Medical Staff Services Office, in person or by certified mail, return receipt requested.

The decision shall uphold or reverse the final written decision rendered by the decision making body, or may remand the case for reconsideration by the decision making body. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board within thirty (30) days. The final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review.

SECTION 10 RIGHT TO ONE HEARING AND ONE APPEAL ONLY

- 10.1 No applicant or Medical Staff practitioner shall be entitled to more than one (1) hearing and one (1) appeal on any matter that may be the subject of an appeal. A final appellate decision upholding or reversing a final, written decision shall be final and there shall be no right to further hearing on the matter.
- 10.2 If the Board determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current practitioner, that practitioner may not apply for Staff appointment or for those clinical privileges at this hospital for a period of five (5) years unless the Board provides otherwise.

PART III: CREDENTIALING PROCEDURES

SECTION 1 SYSTEM CREDENTIALING/PRIVILEGING COMMITTEE

1.1 Organizational Structure

It is the intention of the Medical Staff Organizations of Lee Memorial Health System (LMHS) to ultimately establish one (1) System Credentialing/Privileging Committee (hereinafter referred to as the Credentialing/Privileging Committee) to act on behalf of all the Medical Staff of LMHS. It has been determined that the two (2) Credentialing/Privileging Committees in effect at the time of the approval of this document may continue for a maximum period of two (2) years. During this transition time, the two (2) Credentialing/Privileging Committees will meet jointly on at least a quarterly basis (the Credentialing/Privileging Committees will not meet separately during the months that the joint meetings occur) and through this process will effect a smooth transition to a single System Credentialing/Privileging Committee. The single System Credentialing/Privileging Committee may decide to merge prior to the end of the two 2-year period.

1.2 Transition Issues

At the time of adoption of PART III, two (2) Credentialing/Privileging Committees exist. Chairs of each of these Credentialing/Privileging Committees have been appointed in accordance to procedures that were in existence prior to the adoption of these Credentials Procedures. During the transition period (moving from two (2) committees to a single System Credentialing/Privileging Committee), these Chairs will continue to serve as the Chairs of the applicable practitioner System Credentialing/Privileging Committee and together will serve as Co-Chairs of the System Credentialing/Privileging Committee (which will meet at least quarterly (see Section 1.1)).

The initial composition of the System Credentialing/Privileging Committee will be made up of the membership of the two (2) separate Credentialing/Privileging Committees, with the current Chairs serving as Co-Chairs. During the first year of the System Credentialing/Privileging Committee, the committee will plan to evolve to the composition of the System Credentialing/Privileging Committee as established in Section 1.4 by the end of twenty-four (24) months.

1.3 Purpose of the System Credentialing/Privileging Committee

The System Credentialing/Privileging Committee exists to oversee all credentialing and privileging activities related to Medical Staff members and privileged Allied Health practitioners on behalf of the Facility Medical Executive Committees (FMECs). These credentialing and privileging activities include processes related to the following:

- 1.3.1 initial appointment;
- 1.3.2 focused professional practice evaluation;
- 1.3.3 reappointment;
- 1.3.4 delineation of clinical privileges, including temporary privileges; and
- 1.3.5 development of privilege delineation forms and criteria for all LMHS facilities.

Credentialing activities are to be carried out in accordance with specific policies and procedures developed to ensure current clinical competency of the practitioners who are credentialed and privileged at LMHS. The purpose of the System Credentialing/Privileging Committee also includes development of implementation of credentialing and privileging policies and procedures designed to ensure compliance with regulatory requirements.

1.4 Composition of the System Credentialing/Privileging Committee

The leadership and membership of the System Credentialing/Privileging Committee shall be as follows:

- 1.4.1 Consist of not less than 15 members of the active Medical Staff selected on a basis that will ensure, insofar as feasible, balanced representation of the LMHS sites.
- 1.4.2 The System Medical Director will serve as a non-voting member.
- 1.4.3 The Immediate Past President of each FMEC will serve as voting members and will serve a 2-year term. The FMEC may appoint this practitioner, as a member once the Immediate Past President is no longer in office.
- 1.4.4 Each FMEC will appoint two (2) additional representatives.
- 1.4.5 A quorum of 50% is required to conduct a meeting.
- 1.4.6 Members shall serve for two (2) years and may be reappointed to consecutive terms.
- 1.4.7 Each member shall be required to attend 75% of the meetings during the Medical Staff year. Failure to attend 75% of the meetings may result in dismissal of the member from committee service and selection of an alternative member by the affected FMEC.
- 1.4.8 The committee members from among the committee membership will elect the Co-Chairs of the System Credentialing/Privileging Committee. One of the Co-Chairs will be from a medical specialty and the other Co-Chair will be from a surgical specialty.

1.5 Duties and Responsibilities of the System Credentialing/Privileging Committee

The System Credentialing/Privileging Committee shall:

- 1.5.1 Meet to evaluate credentialing-related requests (initial appointment, reappointment, requests for clinical privileges and leave of absence, etc.) on behalf of the FMECs.
- 1.5.2 Monitor the granting of temporary privileges to assure that temporary privileges are granted in compliance with approved policies and procedures. (The System Credentialing/Privileging Committee does not evaluate requests for temporary privileges. These requests are handled in accordance with specific policies and procedures that are overseen by the System Credentialing/Privileging Committee).
- 1.5.3 Oversee the processes related to focused professional performance evaluations and related proctoring and other mechanisms and tools employed to evaluate competency.
- 1.5.4 Assure uniformity in both the development and application of privileging criteria utilized throughout LMHS facilities.

- 1.5.5 Assure the FMECs and Board that Medical Staff Bylaws Provisions that relate to credentialing and privileging processes are being fulfilled, as well as credentialing policies and procedures and other credentialing-related Medical Staff documents. Monitor compliance with all credentialing and privileging policies and procedures.
- 1.5.6 Be responsible for evaluating recommendations made by Department Chairs. The committee is looking for completeness, thoroughness and adherence to credentialing and privileging policies and criteria. Assure the FMECs that specialty-specific criteria for clinical privileges comply with Medical Staff Bylaws, credentialing policies and procedures, and criteria is applied fairly and uniformly to each practitioner.
- 1.5.7 Focuses in on the files that are determined to need clarification or additional information (i.e., time gaps, problems with references, malpractice claims, etc.) and assures that all issues have been appropriately addressed and that there is complete and thorough documentation for the recommendation(s) that have been made to the FMECs.
- 1.5.8 Be responsible and aware of regulatory requirements related to credentialing activities and to make the FMECs and Board aware when changes in credentialing policies and procedures need to be made in order to meet requirements.
- 1.5.9 Commission, receive and analyze the results of compliance audits of credentialing and privileging processes. The System Credentialing/Privileging Committee makes recommendations to the FMECs and the Board when the System Credentialing/Privileging Committee believes, based on results of reports that improvements can and should be made in credentialing and privileging policies and procedures.

SECTION 2 QUALIFICATIONS FOR MEMBERSHIP AND PRIVILEGES

2.1 The following qualifications must be met by all applicants for Medical Staff appointment, reappointment or clinical privileges:

- 2.1.1 Associate and Active Staff shall live and maintain an office in Lee County, unless this requirement is waived by the FMEC;
- 2.1.2 Demonstrate that he has successfully graduated from an approved school of medicine (MD or DO), dentistry, podiatry, clinical psychology or applicable recognized course of training in a clinical profession eligible to hold privileges;
- 2.1.3 Have a current unrestricted state or federal license as a physician, dentist, podiatrist or clinical psychologist, applicable to his or her profession, and providing permission to practice within the State of Florida;
- 2.1.4 Have a record that is free from current Medicare/Medicaid sanctions and not be on the Office of Inspector General (OIG) or General Services Administration (GSA) List of Excluded practitioners/entities;
- 2.1.5 Have a record that is free of felony convictions or occurrences that would raise questions of undesirable conduct, which could injure the reputation of the Medical Staffs, hospital or Health System;

- 2.1.6 A physician (MD or DO) must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified following the completion of formal training within the timeframes as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association. If no time limits for certification are specified by a given Board, then the applicant will be required to become Board certified within seven (7) years of completing formal training as defined by the appropriate specialty Board of the American Board of Medical Specialties or the American Osteopathic Association. If an applicant is beyond seven (7) years of completing formal training, current Board certification will be required for consideration of membership and privileges. Once a member of the Medical Staff becomes Board certified, recertification is not a requirement of continued membership and privileges;
- 2.1.7 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;
- 2.1.8 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;
- 2.1.9 A podiatric physician (DPM) must have successfully completed a two 2-year residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;
- 2.1.10 A psychologist, must have earned a doctorate degree, (PhD or Psy.D. in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one 1-year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA);
- 2.1.11 Possess a current, valid, Drug Enforcement Administration (DEA) number if applicable to the privileges requested;
- 2.1.12 Have appropriate written and verbal communication skills;
- 2.1.13 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:
 - 2.1.13.1 Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities;

- 2.1.13.2 A history of consistently acting in a professional, appropriate and collegial manner with others in previous clinical and professional settings.
- 2.1.14 The following qualifications must also be met by all applicants requesting clinical privileges:
 - 2.1.14.1 Demonstrate his background, experience, training, current competence, knowledge, judgment and the ability to perform all privileges requested.
 - 2.1.14.2 Provide evidence of both physical and mental health that does not impair the fulfillment of his responsibilities of Medical Staff membership and the specific privileges requested by and granted to the applicant, upon request.
 - 2.1.14.3 Any practitioner granted privileges that may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the FMEC and Board.
 - 2.1.14.4 Demonstrate recent clinical performance (within the last twelve (12) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria.
 - 2.1.14.5 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved Medical Staff development plan.
 - 2.1.14.6 Provide evidence of financial responsibility consistent with the requirements set forth in Part I.

2.1.15 Exceptions:

All practitioners who are current Medical Staff members and/or hold privileges as of May 28, 2009 and who have met prior qualifications for membership and/or privileges shall be exempt from Board specialty certification requirements.

SECTION 3 PRE-APPLICATION PROCESS

- 3.1 Only those practitioners that meet the following minimum criteria for appointment to the Medical Staff will be provided applications. Practitioners provided applications would be those:
 - 3.1.1 which are not governed by an exclusive arrangement or who are joining a group providing services governed by an exclusive arrangement; and
 - 3.1.2 who meet the minimum criteria as developed by the System Credentialing/Privileging Committee and approved by FMECs and the Board.

The purpose for the pre-application screening process shall be to avoid the costly and time-consuming application process in those circumstances where an applicant

fails to meet minimum eligibility criteria. Practitioners who do not meet the minimum eligibility criteria for appointment are not entitled to fair hearing rights.

The System Credentialing/Privileging Committee shall review all requests for application and determine whether the criteria for issuing an application have been met.

SECTION 4 INITIAL APPOINTMENT PROCESS

4.1 Completion of Application

- 4.1.1 All requests for application for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff Services Department. If the applicant successfully completed the pre-application screening process, the Medical Staff Services Department will provide the applicant an application packet, which will include a complete set or overview of the relevant Medical Staff Bylaws or reference to an electronic source for this information. This packet will enumerate the eligibility requirements for Medical Staff membership (for each facility of LMHS) and/or privileges and a list of expectations of performance for practitioners granted Medical Staff membership or privileges (if such expectations have been adopted by each Facility Medical Staff).

A completed application includes, at a minimum:

- 4.1.1.1 a completed, signed, dated application form;
- 4.1.1.2 a completed privilege delineation form if requesting privileges;
- 4.1.1.3 copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
- 4.1.1.4 all applicable fees;
- 4.1.1.5 complete reference information; references shall be from peers (same specialty) knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;
- 4.1.1.6 relevant practitioner-specific data as compared to aggregate data, when available
- 4.1.1.7 morbidity and mortality data, when available.

Each applicant must indicate the LMHS facility anticipated to be his primary facility (i.e., the facility where the majority of his clinical activity is performed). It should be noted that this designation is important for credentialing purposes (interviews, implementation of focused professional practice evaluation, etc.) and will be confirmed by LMHS data at periodic intervals and prior to any subsequent reappointments.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional or clarifying information

in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing.

Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken. Applications will not be accepted from practitioners that are not eligible to take the Board certification examination.

- 4.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff Services Department receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the Health System that the applicant meets the requirements for the Medical Staff membership and/or the privileges requested. If information is missing from the application or new, additional or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff Services Department within thirty (30) calendar days of the receipt of the requested letter, the application will be deemed to have been voluntarily withdrawn.
- 4.1.3 Upon receipt of a completed application, the System Medical Director will determine if the requirements of Section 2.1 are met. In the event the requirements of Section 2.1 are not met, the applicant will be notified that he is ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of Section 2.1 are met, the application will be accepted for further processing.
- 4.1.4 Practitioners seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, other qualifications and of resolving any doubts.
- 4.1.5 Upon receipt of a completed application, the Medical Staff Services Department will verify current licensure, education, relevant training and current competence from the primary source whenever feasible in accordance with the Verification Methods and Requirements document.

When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source.

Note: In the event there is undue delay in obtaining required information, the Medical Staff Services Department will request assistance from the applicant. During this time, the period for processing, the application will be appropriately modified. Failure of an applicant to respond to a request for assistance adequately after thirty (30) calendar days the application will be deemed to have been voluntarily withdrawn.

- 4.1.6 When all items identified in the Verification Methods and Requirements document have been obtained and verified, the application will be considered eligible for evaluation.

4.2 Applicant's Attestation, Authorization and Acknowledgement

4.2.1 The applicant must complete and sign the application form. By signing this application the applicant:

4.2.1.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any inaccuracy, omission or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal.

If the inaccuracy, omission or misstatement is discovered after a practitioner has been granted appointment and/or clinical privileges, the practitioner's appointment and privileges shall lapse effective immediately upon notification of the practitioner without the right to a fair hearing or appeal.

4.2.1.2 Consents to appear for any requested interviews about his application.

4.2.1.3 Authorizes the applicable hospital and Medical Staff representative to consult with prior and current associates and others who may have information bearing on his professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others and other qualifications for requested membership and/or clinical privileges.

4.2.1.4 Consents to the Health System and Medical Staff representatives' inspections of all records and documents that may be material to an evaluation of:

4.2.1.4.1 professional qualifications and competence to carry out the clinical privileges requested;

4.2.1.4.2 physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

4.2.1.4.3 professional and ethical qualifications;

4.2.1.4.4 professional liability actions including currently pending claims involving the applicant;

4.2.1.4.5 any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

4.2.1.5 Releases from liability, promises not to sue and grants immunity to the Health System, its Medical Staffs and its representatives for acts performed and statements made in good faith in connection with evaluation of the application and his credentials and qualifications fully permitted by the law.

4.2.1.6 Releases from liability and promises not to sue, all practitioners and organizations who provide information to the Health System or the applicable Medical Staff(s) in good faith, including otherwise privileged or

confidential information to the System/hospital representatives concerning his background/experience, competence, professional ethics, character, physical and mental health to the extent relevant to the capacity to fulfill requested privileges, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges.

4.2.1.7 Authorizes the Health System, Medical Staff and Administrative representatives to obtain credentialing and peer review information from other hospitals, medical associations, licensing boards, appropriate government bodies and other health care entities concerned with this provider's performance and releases representatives of the Health System from liability for so doing.

4.2.1.8 Acknowledges that the applicant has had access to relevant Medical Staff Bylaws, including all rules, regulations, policies and procedures of the relevant Medical Staffs and agrees to abide by their provisions.

Notwithstanding Section 3.2 of Part II, if a practitioner institutes legal action and does not prevail, he shall reimburse the Health System and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

4.2.1.9 Agrees to provide accurate answers to all the questions on the application form, and agrees to immediately notify the System in writing should any of the information regarding these items change during the period of the applicant's Medical Staff membership and/or privileges.

4.3 Application Evaluation

4.3.1 Expedited Credentialing:

4.3.1.1 An expedited Credentialing/Privileging Committee review and approval process may be used for initial appointment in accordance with the Expedited Credentialing Policy.

4.3.2 Applicant Interview

4.3.2.1 All applicants for appointment to the Medical Staff and/or the granting of clinical privileges are required to participate in interviews. The interviews are used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community and in compliance with LMHS privileging criteria. Interviews may also be used to communicate Medical Staff performance expectations.

Applicants for appointment will participate in a minimum of two (2) interviews. One interview will be conducted by the applicable Department Chair or designated Section Chief of the applicant's anticipated primary LMHS facility and the second interview will be with a member of the System Credentialing/Privileging Committee. Applicants that are applying for multiple facilities within LMHS may be required to

participate in additional Department Chair/Section Chief interviews at the discretion of the Department Chairs of the facility(ies) that are designated as non-primary.

- 4.3.2.2 Procedure: the applicant will be notified of required interview(s). Failure of the applicant to appear for a scheduled interview will be deemed a voluntary withdrawal of the application.

4.3.3 Department Chair Action

- 4.3.3.1 Each Department Chair of an LMHS facility where the applicant has requested privileges makes a recommendation related to membership and privileges, as applicable.

All completed applications are presented to the appropriate Department Chair(s) for review and recommendation (which is made by completion of a standardized form provided to the Chair by the Medical Staff Services Department). The Department Chair(s) reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chair(s) may obtain input if necessary from an appropriate subject matter expert(s).

If a Department Chair believes a conflict of interest exists that, might preclude his ability to make an unbiased recommendation, he will notify the Medical Staff Services Department and forward the application without comment.

- 4.3.3.2 The Department Chair(s) forwards to the System Credentialing/Privileging Committee the following:

- 4.3.3.2.1 A written recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges (a summary of the interview conducted by the Department Chair or his designee is included in this written recommendation);

- 4.3.3.2.2 Written comments supporting his recommendations.

The Department Chair of the applicant's anticipated primary facility also makes a written recommendation to define those circumstances, which require monitoring and evaluation of clinical performance after the initial granting of clinical privileges (i.e., focused professional practice evaluation).

4.3.4 Medical Staff System Credentialing/Privileging Committee Action

- 4.3.4.1 The System Credentialing/Privileging Committee reviews the application and forwards the following to the applicable FMEC(s):

- 4.3.4.1.1 A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;

- 4.3.4.1.2 A recommendation to define those circumstances, which require monitoring, and evaluation of clinical performance after initial granting of clinical privileges (Focused Professional Practice Evaluation) (FPPE);

Comments supporting the above recommendation.

4.3.5 FMEC Action

- 4.3.5.1 Each FMEC of LMHS where membership and/or privileges have been requested forwards the following to the Board:

- 4.3.5.1.1 A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;

- 4.3.5.1.2 Comments supporting the above recommendation.

The FMEC of the applicant's anticipated primary facility also makes a recommendation to define those circumstances that require monitoring and evaluation of clinical performance after initial granting of clinical privileges (FPPE).

Whenever a FMEC makes an adverse recommendation to the Board, a notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in the Investigation, Corrective Action, Hearing and Appeal Plan of the Medical Staff Bylaws. When multiple FMECs are making recommendations related to the same applicant, an adverse recommendation is not considered final until after the PLC attempts to facilitate resolution of the issues (this facilitation occurs when there are disparate recommendations – for example, one (1) positive recommendation and one negative recommendation).

4.3.6 Applicants Applying to Multiple Facilities

Applicants may simultaneously make application for membership and/or privileges to multiple facilities within LMHS. The Medical Staff Services Department coordinates this information so that the recommendations from all FMECs come to the Board together. If there are disparate recommendations (defined as conflicting) related to membership and/or requested clinical privileges on the same applicant, the PLC will meet and attempt to reconcile the disparate recommendations prior to forwarding the recommendations to the Board.

If the PLC is unable to facilitate resolution of the issues (in accordance with the Medical Staff Bylaws – Part I, Governance – Section 9 Decision Making Methods and Conflict Resolution) the disparate recommendations will go forward to the Board.

4.3.7 Board Action:

- 4.3.7.1 The Board reviews the recommendation and votes for one (1) of the following actions:

- 4.3.7.1.1 The Board may adopt or reject in whole or in part a recommendation of the FMEC(s) or refer the recommendation to the FMEC(s) for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made.
- 4.3.7.1.2 If the Board concurs with the applicant's request for membership and/or privileges, it will grant the appropriate membership and/or privileges for a period not to exceed 24 months.
- 4.3.7.1.3 If the Board's action is adverse to the applicant, a notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in the Medical Staff Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) unless the applicant received procedural rights under Part II, Section 3.2.5.
- 4.3.7.1.4 The Board shall take final action in the matter as provided in the Medical Staff Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

4.3.8 Notice of Final Decision:

- 4.3.8.1 Notice of the Board's final decision shall be given through the Medical Staff Services Department to the applicable FMEC(s) and to the Chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category(ies) to which the applicant is appointed, the Department(s) to which he is assigned, the clinical privileges he may exercise, notification of orientation and any special conditions attached to the appointment.

4.3.9 Periods for Processing:

- 4.3.9.1 All practitioners and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and except for good cause, each application will be processed within 180 calendar days. The 180 Calendar days begin on the date that the application is declared complete to begin processing.
- 4.3.9.2 These processing periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of the Medical Staff Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued process of the application.

SECTION 5 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

5.1 CRITERIA FOR FPPE

- 5.1.1 The Department Chair (or designated Section Chief) of the applicant's anticipated primary facility will define circumstances that require monitoring and evaluation of the clinical performance of each practitioner following his or her initial granting of clinical privileges.

Such monitoring may utilize a range of techniques, including but not limited to: chart review, the tracking of performance monitors/indicators, proctoring, external peer review, simulations, morbidity/mortality reviews, and discussion with other healthcare practitioners involved in the care of each patient. The FPPE plan is created as part of the initial recommendation for appointment and privileges and is forwarded to the System Credentialing/Privileging Committee and to the FMEC(s).

The System Credentialing/Privileging Committee will establish via policy the anticipated duration for FPPE.

The Physician Quality Committee will establish the triggers that indicate the need for performance monitoring after the initial granting of privileges.

SECTION 6 CRITERIA FOR REAPPOINTMENT

6.1 Criteria for Reappointment

- 6.1.1 It is the policy of the Health System to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 2, Part 1. The practitioner must also be determined by each applicable FMEC to be a provider of effective care that is consistent with the Health System standards of ongoing quality and the hospital performance improvement program and provide the information enumerated in Section 5.1.1.

All reappointments and renewals of clinical privileges are for a period not to exceed 24 months. The granting of new clinical privileges to existing Medical Staff members will follow the steps described in Section 4 concerning the initial granting of new clinical privileges and Section 5 concerning FPPE. A suitable peer shall substitute for the Department Chair in the evaluation of current competency of the Department Chair, and recommend appropriate action to the System Credentialing/Privileging Committee.

In the event a practitioner finds no need to utilize the facilities or resources of LMHS for purposes of patient care through either admission, performance of a procedure, consultation, or referral, during a two-year period he may not be eligible for reappointment or continued privileges. Such practitioner may apply as a new applicant at any time subsequent to the expiration of the current appointment or privileges. This provision applies to practitioners who have been granted a leave of absence, moved their practice location, established a relationship with another institution or otherwise find no need to utilize the clinical resources of LMHS. Exceptions to this provision may be made by the Board upon recommendation of the applicable FMEC(s).

As long as a practitioner has adequate clinical activity to maintain privileges at one LMHS facility (and is recommended for continuation of privileges at his primary LMHS facility) the practitioner may maintain the applicable clinical privileges and staff category (potentially Associate if there is no or minimal clinical activity) at other LMHS facility(ies).

6.2.1 Information, Collection and Verification

6.2.1.1 From practitioner: On or before 4 months prior to the date of expiration of a Medical Staff appointment or granting of privileges, a representative from the Medical Staff Services Department notifies the practitioner of the date of expiration and supplies him with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date, the practitioner must return the following to the Medical Staff Services Department:

6.2.1.1.1 A completed reapplication form, which includes complete information to update his file on items listed in his original application, any required new, additional, or clarifying information, and any required fees or dues;

6.2.1.1.2 Information concerning continuing training and education internal and external to the hospital during the preceding period;

6.2.1.1.3 By signing the reapplication form, the practitioner agrees to the same terms as identified in Section 4.2.

6.2.2 From internal and/or external sources: The Medical Staff Services Department collects and verifies information regarding each staff practitioner's professional and collegial activities to include those items listed in Section 2.1.

6.2.3 The following information is also collected and verified:

6.2.3.1 A summary of clinical activity at each LMHS facility for each practitioner due for reappointment.

6.2.3.2 Performance and conduct in each LMHS facility and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice.

6.2.3.3 Documentation of CME activity;

6.2.3.4 Service on Medical Staff, Department and hospital committees;

6.2.3.5 Timely and accurate completion of medical records;

6.2.3.6 Compliance with all applicable Bylaws, policies, rules, regulations, and procedures of the System and the Medical Staff(s);

6.2.3.7 Any significant gaps in employment or practice since the previous appointment or reappointment; and

6.2.3.8 Additional items as identified in the Verification Methods and Requirements document.

6.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff Services Department verifies this additional information and notifies the staff practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

6.3 Evaluation of Application for Reappointment of Membership and/or Privileges

6.3.1 The reappointment application will be reviewed and acted upon as described in Sections 4.3.3 through 4.3.8. For the purpose of reappointment, an “adverse recommendation” by the Board as used in Section 4.3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action that would entitle the applicant to a Fair Hearing under the Medical Staff Bylaws. The terms “applicant” and “appointment” as used in these Sections shall be read respectively, as “staff practitioner” and “reappointment”.

SECTION 7 CLINICAL PRIVILEGES

7.1 Exercise of Privileges

A practitioner providing clinical services at a LMHS facility may exercise only those privileges granted to him by the Board or emergency and disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the FMEC(s) to practitioners who are not members of the Medical Staff. Such practitioners may include Advanced Registered Nurse Practitioners (ARNPs), Physician Assistants (PAs), practitioners serving short locum tenens positions, telemedicine physicians or others deemed appropriate by the FMEC(s) and Board.

7.2 Requests

When applicable, each application for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

7.3 Basis for Privileges Determination

7.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the System in its Board approved criteria for clinical privileges.

7.3.2 Privileges for which no criteria have been established:

7.3.2.1 In the event a request for a privilege is submitted for a new technology, a procedure new to the System, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this

time, the System Credentialing/Privileging Committee may refer the request for review by a task force appointed to review the request.

Task forces formed for purposes of establishment of evaluation of new privileges and potential determination of criteria will be appointed by the Chairs of the System Credentialing/Privileging Committee, and will include the System Medical Director of Clinical Effectiveness and the Director of Supply Chain Management. The task force will:

- 7.3.2.1.1 Review the community, patient and System need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;
 - 7.3.2.1.2 Review with appropriate individuals/groups the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);
 - 7.3.2.1.3 Meet with management to ensure that the new privilege is consistent with the Health System's mission, values, strategic, operating, capital, information and staffing plans;
 - 7.3.2.1.4 Work with management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the System Credentialing/Privileging Committee and appropriate clinical services/specialty or subject matter experts (as determined by the System Credentialing/Privileging Committee), the criteria will be recommended to each FMEC and then to the Board. Once objective criteria have been established, the original request will be processed as described herein.
- 7.3.2.2 For the development of criteria, the Medical Staff Services Department (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organization, position and opinion statements from interested individuals or groups and documentation from other hospitals in the region as appropriate.
- 7.3.2.3 Criteria to be established for the privilege(s) in question include education, training, board status or certification (if applicable), experience and evidence of current competence. Proctoring requirements, if any, will be addressed including who may serve as proctor and how many proctored cases will be required.

Hospital related issues such as exclusive contracts, equipment, clinical support staff and management would be referred to the appropriate hospital administrator and/or Department Director.

- 7.3.2.4 If the privileges requested overlap two (2) or more specialty disciplines, an ad hoc committee may be appointed by the System

Credentialing/Privileging Committee to recommend criteria for the privilege(s) in question. This ad hoc committee will consist of at least one (1) but no more than two (2) members from each involved discipline. The Chair of the ad hoc committee will be a member of the System Credentialing/Privileging Committee who has no vested interest in the issue (see Medical Staff Privilege Dispute Resolution Policy).

- 7.3.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the System's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the staff's performance improvement program activities.

Privilege determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and healthcare settings where the practitioner exercises clinical privileges.

- 7.3.4 The procedure by which requests for clinical privileges are processed are as outlined in Section 4.

7.3.5 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.

- 7.3.6 Special Conditions for practitioners not Qualified for Medical Staff Appointment but Practicing Pursuant to Clinical Privileges per System Policy.

Requests for privileges, from such practitioners, are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception that such practitioners are not eligible for membership on a Medical Staff and do not have the rights and privileges of such membership (all rights and responsibilities are defined in the Allied Health Practitioner (AHP) Privileging Policy and Procedure).

Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges.

AHP(s) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care.

7.4 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests.

Practitioners granted podiatric privileges may perform and shall record in the medical record a basic medical evaluation history and physical for the practitioner's podiatric patients if consistent with the privileges granted to the practitioner, state law governing the practitioner's practice and federal law.

7.5 Special Conditions for Residents or Fellows in Training

Residents or Fellows in Training in the Health System shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Professional Graduate Education Committee in conjunction with the Residency Training Program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and hospital leaders.

The Post-Graduate Education Program Director or Committee must communicate periodically with each applicable FMEC and the Board about the performance of its residents, patient safety issues and quality of patient care and must work with the FMEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

7.6 Special Conditions for the Aging Practitioner

At the age of 70, practitioners shall complete an annual examination that addresses both the physical and mental capacity for the privileges requested.

The annual physical and mental exams are to be conducted by an independent Medical examiner acceptable to the System Credentialing/Privileging Committee, documented on the approved form and submitted to the System Credentialing/Privileging Committee by the date requested. The physical exam is a "fitness to work" evaluation and must indicate that the practitioner has no physical or mental problem that may interfere with the safe and effective provision of care permitted under the privileges granted. In addition to the physical exam, a practitioner may be required to undergo proctoring of his clinical performance as part of the assessment of his capacity to perform the requested privileges. Such proctoring may be required in the absence of any previous performance concerns.

The scope and duration of the proctoring shall be determined by the FMEC upon recommendation of the Department Chair of the practitioner's primary facility and System Credentialing/Privileging Committee.

The practitioner shall pay the cost of the physical and mental exam.

7.7 Temporary Privileges

- 7.7.1 Temporary privileges may be granted by the CEO, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee to be approved at the next FMEC meeting, provided there is verification of current licensure and current competence. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the FMEC and the Board. Applications pending completion of the initial appointment process must always be reviewed and a recommendation made by the System Credentialing/Privileging Committee prior to the granting of temporary privileges.
- 7.7.2 Important Patient Care, Treatment or Service Need: Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited time, not to exceed 30 calendar days (from date privileges are granted). Temporary privileges may be extended for two separate 30-day intervals upon approval of the Board of Directors. For the purposes of granting temporary privileges, an important patient care, treatment or service need is defined as including the following:
- 7.7.2.1 a circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted, (i.e., a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner);
 - 7.7.2.2 a circumstance in which the institution will be placed at risk of not adequately meeting the needs of patients who seek care, treatment or service from the institution if the temporary privileges under consideration are not granted (i.e., the institution will not be able to provide adequate emergency room coverage in the providers specialty, or the Board has granted privileges involving new technology to a physician on the staff provided the physician is precepted for a specific number of initial cases and the precepting physician, who is not seeking Medical Staff membership, requires temporary privileges to serve as a preceptor);
 - 7.7.2.3 a circumstance in which a group of patients in the community will be placed at risk if not receiving patient care that meets their clinical needs if the temporary privileges under consideration are not granted (i.e. a physician who has a large practice in the community for which adequate coverage of hospital care for those patients cannot be arranged).
- 7.7.3 Clean Application (Expedited) Awaiting Approval: Temporary privileges may be granted for up to 30 calendar days (from date privileges are issued) approved by the Executive Committee with two 30-day extensions approved by the Board (see the policy and procedure on Expedited Credentialing) when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the FMEC and approval by the Board.
- 7.7.4 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his temporary privileges. Whether or not such written

agreement is obtained, these Bylaws, rules, regulations and policies control all matters relating to the exercise of clinical privileges.

- 7.7.5 Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature, which raises questions about a practitioner's privileges.

Where the life or well-being of a patient is determined to be endangered, any person entitled to impose precautionary suspension under the Medical Staff Bylaws may effect the termination. In the event of any such termination, the CEO or his designee then will assign the practitioner's patients to another practitioner. The wishes of the patient shall be considered when feasible, in choosing a substitute practitioner.

- 7.7.6 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in the Medical Staff Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his request for temporary privileges is refused or because all or any part of his temporary privileges are terminated or suspended unless based on a determination of clinical incompetence or unprofessional conduct.

- 7.7.7 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of facility affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

- 7.7.8 Disaster Privileges

7.7.8.1 If the System's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and such other individuals as identified in the System's Disaster Plan with such authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to provide patient care to selected Licensing Independent Practitioners (LIP's), who must at a minimum present a valid governmental-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

7.7.8.1.1 a current picture hospital ID card that clearly identifies professional designation;

7.7.8.1.2 a current license to practice;

7.7.8.1.3 primary source verification of the license;

7.7.8.1.4 identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

- 7.7.8.1.5 identification indicating that the practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);
- 7.7.8.1.6 identification by a current hospital or Medical Staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a LIP during a disaster.
- 7.7.8.2 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.
- 7.7.8.3 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
- 7.7.8.4 Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.
- 7.7.8.5 Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised at the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

SECTION 8 PRECEPTORSHIP

- 8.1 A practitioner who has not provided acute inpatient care within the past 24 months who requests clinical privileges at the hospital must arrange for a preceptorship either with a current member in good standing of the Medical Staff who practices in the same specialty or with an academic training program or other equivalently competent physician practicing outside of the hospital. The practitioner must assume responsibility for any financial costs required to fulfill the requirements of Sections 8.1 and 8.2.
- 8.2 A description of the preceptorship program, including details of monitoring and consultation must be written and submitted for approval to the applicable Department Chair, System Credentialing/Privileging Committee and FMEC. At a minimum, the preceptorship program description must include the following:
 - 8.2.1 The scope and intensity of required preceptorship activities;
 - 8.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get

along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

SECTION 9 REAPPLICATION AFTER MODIFICATIONS OF MEMBERSHIP STATUS OF PRIVILEGES AND EXHAUSTION OF REMEDIES

9.1 Reapplication After Adverse Credentials Decision

9.1.1 Except as otherwise determined by the Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment, reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Board requires, demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

9.2 Request for Modification of Appointment Status or Privileges

9.2.1 A staff member, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the Medical Staff Services Department. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 6 of this manual. A practitioner who determines that he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he has been granted shall send written notice, through the Medical Staff Services Department to the System Credentialing/Privileging Committee, and FMEC. A copy of this notice shall be included in the practitioner's credentials file.

9.3 Resignation of Staff Appointment or Privileges

9.3.1 A practitioner who wishes to resign his staff appointment and/or clinical privileges must provide written notice to the appropriate Department Chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his staff appointment and/or clinical privileges is obligated to accurately complete all portions of all medical records for which he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

9.4 Exhaustion of Administrative Remedies

9.4.1 Every practitioner agrees that he will exhaust all the administrative remedies afforded in the various Sections of Part I: Governance, Part II: Investigations, Corrective Action, Hearing and Appeal Plan and Part III: Credentialing Procedures before initiating legal action against the System or its agents.

9.5 Reporting Requirements

9.5.1 The CMO or his designee shall be responsible for assuring that the hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes. Actions that must be reported include any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment, reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

SECTION 10 LEAVE OF ABSENCE

10.1 Leave Request

10.1.1 A leave of absence is a matter of courtesy, not of right. In the event that it is determined that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal. A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than thirty (30) days if such absence is related to the practitioner's physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the President of the Medical Staff stating the reasons for the leave and approximate period of the leave, which may not exceed one 1-year except for military service or express permission by the Board. Requests for leave must be forwarded, with a recommendation from the FMEC, and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities.

10.2 Termination of Leave

10.2.1 At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the President of the Medical Staff. The practitioner must submit a written summary of relevant activities during the leave if the FMEC or Board so requests.

A practitioner returning from a leave of absence for health reasons must provide a report from his physician that answers any questions that the FMEC or Board may have as part of considering the request for reinstatement. The FMEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and for privileges is due to expire during the leave of absence, the practitioner must apply for reappointment or his appointment and/or clinical privileges shall lapse at the end of the appointment period.

10.3 Failure to Request Reinstatement

10.3.1 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 practitioner whose membership is automatically terminated shall not be entitled to the procedural rights provided in the

Medical Staff Bylaws. 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.

SECTION 11 PRACTITIONERS PROVIDING CONTRACTED SERVICES

11.1.1 When the System or hospital contracts for patient care services with LIPs who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are under the control of a Joint Commission accredited organization, the hospital will:

11.1.1.1 specify in a contract that the entity providing these services by contract (the contracting entity) will ensure that all services provided under this contract by individuals who are LIPs will be within the scope of those practitioner's privileges at the contracting entity; or

11.1.1.2 verify that all individuals who are LIPs and providing services under the contract have privileges that include the services provided under the contract.

11.2 When the System/hospital contracts for care services with LIPs, who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are not under the control of a Joint Commission accredited organization, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

11.3 Contract Services/Department or Service Closure

11.3.1 The membership and privileges on the Medical Staff of any practitioner who has a contractual relationship with the System or with an entity that has a contractual relationship with the System to provide professional services to patients shall be subject to those provisions contained in said contract with regard to the termination of Medical Staff membership and privileges upon the expiration, lapse, cancellation or termination of the contract. If the contract so provides, the affected practitioner shall have no right to a hearing regarding termination of Medical Staff membership or privileges.

11.3.2 In the event a hospital Department is closed, discontinued or provided through an exclusive contract, such establishment shall not adversely impact the ability of any physician to continue to maintain clinical membership and exercise privileges in existence at the time of such closure, discontinuance or exclusive contract. Initial applications for Medical Staff membership and privileges will not be extended, provided, accepted, processed or approved to or from physicians unless they are joining groups who are actively contracted for exclusively contracted services.

11.3.3 In the event the Board determines that a patient care service shall be closed, discontinued, or provided through an exclusive contract, such action shall require approval by the affected FMEC.

Both parties agree that any Department or service closure shall occur solely so that the health and wellbeing of the patients and the best interests of the hospital under these Bylaws may be served at all times. Notwithstanding any other provision in the

Bylaws, if the Board and the affected FMEC are unable to agree upon the closure of a Department or service, the matter shall undergo the conflict resolution process set forth in Part I, Section 9 of these Bylaws.

If the parties are still in disagreement regarding the closure of a Department or service upon completion of the conflict resolution process, the parties shall engage in mediation in accordance with the procedures set forth by the American Health Lawyers Association's Alternative Dispute Resolution Service or another independent mediation service mutually agreeable to the parties. In the event the Board and FMEC are at impasse at mediation and conflict remains, the Board and the FMEC retain the right to seek a resolution through litigation. Further, the Board shall not close a Department or service for a period of three months following impasse at mediation.

11.4 Qualifications

11.4.1 A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Health System must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his appointment category as any other applicant or staff practitioner.

11.5 The terms of the Medical Staff Bylaws will govern disciplinary action taken by or recommended by the FMEC.

11.6 Effect of Contract or Employment Expiration or Termination

11.6.1 The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the System. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

SECTION 12 MEDICAL ADMINISTRATIVE OFFICERS

12.1 A Medical Administrative Officer is a practitioner engaged full or part-time by the hospital in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

12.2 Each Medical Administrative Officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his clinical responsibilities and discharge staff obligations appropriate to his staff category in the same manner applicable to all other staff members.

12.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

12.3.1 Where a contract exists between the officer and the Health System, its terms govern the effect of removal from the Medical Administrative Office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.

12.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of

an adverse change in appointment status or clinical privileges on continuance in office will be determined by the Board.

- 12.3.3 A Medical Administrative Officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.

Adoption

THESE BYLAWS, including Part I (Governance) and Appendix A, Part II (Investigations, Corrective Action and Hearing and Appeal Plan) and Part III (Credentialing Procedures), together with any appended Policies and Procedures and appendices, are adopted effective the 28th day of May, 2009 by action of the Medical Staffs and the Board of Directors of the Lee Memorial Health System as attested below. Cape Coral Hospital Medical Staff General Rules and Regulations remain in effect to the extent consistent with these bylaws.

These bylaws are intended to restructure the current organization of the Medical Staffs of the Lee Memorial Health System as follows:

- Medical Staff of Cape Coral Hospital remains as the Medical Staff of Cape Coral Hospital
- Medical Staff of Lee Memorial Health System - Lee Memorial Hospital/HealthPark Medical Center is restructured such that Lee Memorial Hospital, HealthPark Medical Center, and The Children's Hospital each have an organized Medical Staff.
- Medical Staff of Gulf Coast Medical Center remains as the Medical Staff of Gulf Coast Medical Center.


Medical Staff of Cape Coral Hospital

The undersigned President of the Medical Staff of Cape Coral Hospital, hereby attests that the Medical Staff repealed all previous bylaws and approved these bylaws, together with any appended Policies and Procedures and appendices, in accordance with Article VI of said previous bylaws and recommended repeal of all previous bylaws and adoption of these bylaws by the Lee Memorial Health System Board of Directors.



David Reardon, M.D.
President of the Medical Staff

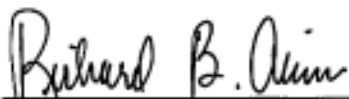
Attest:



Sandra L. Wharton, CPMSM, CPCS
System Director, Medical Staff Services

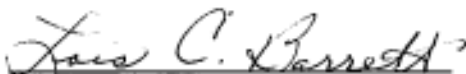
Lee Memorial Health System Board of Directors

The undersigned, Chairman of the Lee Memorial Health System Board of Directors, hereby attests that the Lee Memorial Health System Board of Directors: (i) approved the recommendations of the Medical Staffs of Lee Memorial Health System - Lee Memorial Hospital/HealthPark Medical Center) and (ii) repealed all previous Bylaws of the foregoing Medical Staffs; and (iii) adopted and approved these Bylaws in its entirety as the Bylaws of the Medical Staff of Lee Memorial Health System – Lee Memorial Hospital, HealthPark Medical Center and The Children’s Hospital, together with any appended Policies and Procedures and appendices, by a unanimous affirmative vote at a meeting at which a quorum was present, held on 28th day of May, 2009, in accordance with the applicable provisions of the bylaws, to be effective on the date set forth above.



Richard Akin
Chairman of the Board

Attest:



Lois Barrett, MBA
Secretary